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ABSTRACT

The House of Representatives Select Committee on Children, Youth, and Families was created to provide an ongoing assessment of the conditions of American children and families and to make policy recommendations to Congress and the public. This report on the committee's 1991 activities includes summaries of 11 hearings, a list of witnesses and people who submitted testimony, highlights of legislation affecting children and families, and factsheets. The hearings focused on the following concerns: (1) reclaiming the tax code for American families; (2) generating innovative strategies for healthy infants and children; (3) community-based mental health services for children; (4) police stress and family well-being; (5) creation of a family-friendly workplace for fathers; (6) ways to help teenagers stay safe; (7) effects of noise on hearing loss in children and youth; (8) child abuse treatment and prevention in the 1990s; (9) National Children's Day; (10) comments of the Surgeon General on the prevention of underage drinking; and (11) automotive safety for American families. Most of the hearing summaries are followed by statistical factsheets, and minority position factsheets on health strategies for infants and children, police stress, and working fathers are provided. (AC)

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102D CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

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REPORT ON THE ACTIVITIES FOR THE YEAR 1991

OF THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

HOUSE OF REPRESENTATIVES

102D CONGRESS

FIRST SESSION

Printed for the use of the Select Committee on Children, Youth, and Families

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MEMBERSHIP

The Select Committee on Children, Youth, and Families during the First Session of the 102nd Congress included 36 members. The members are listed below:

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* Resigned October 8, 1991

SUMMARY OF 1991 ACTIVITIES

The Select Committee on Children, Youth, and Families was created by the 98th Congress in 1983 to provide an ongoing assessment of the conditions of American children and families, and to make recommendations to Congress and the public about how to improve public and private sector policies for this constituency.

HEARINGS CONDUCTED

Reclaiming the Tax Code for American Families
April 15, 1991 - Washington, DC

Generating Innovative Strategies for Healthy Infants and Children
April 23, 1991 - Washington, DC

Close to Home: Community-Based Mental Health Services for Children
April 29, 1991 - Washington, DC

On the Front Lines: Police Stress and Family Well-Being
May 20, 1991 - Washington, DC

Babies and Briefcases: Creating a Family-Friendly Workplace for Fathers
June 11, 1991 - Washington, DC

The Risky Business of Adolescence: How to Help Teens Stay Safe, Part I
June 17, 1991 - Washington, DC

The Risky Business of Adolescence: How to Help Teens Stay Safe, Part II
June 18, 1991 - Washington, DC

Turn It Down: Effects of Noise on Hearing Loss in Children and Youth
July 22, 1991 - Washington, DC

Child Abuse Prevention and Treatment in the 1990s: Keeping Old Promises, Meeting New Demands
September 15, 1991 - Denver, CO

National Children's Day: Honoring Our Promises to America's Youth
September 30, 1991 - Washington, DC

Preventing Underage Drinking: A Dialogue with the Surgeon General
November 15, 1991 - Washington, DC

Automotive Safety: Are We Doing Enough to Protect America's Families?
December 4, 1991 - Washington, DC

SITES VISITED

The Joint Delegation visit of the Select Committee on Children, Youth, and Families and the Military Installations and Facilities Subcommittee of the Committee on Armed Services to Hawaii, Kwajalein, Guam, and Alaska included the following site visits to centers serving children and families:

Child Care Center and Family Child Care Providers, Marine Corps Air Station, Kaneohe Bay, Hawaii - Center-based programs and home-based child care provide early childhood educational services and care to more than 400 children of single-parent and dual-military parent families. As of July 1991, almost 300 children were on a waiting list.

Navy Family Service Center, Guam - Center provides single location four counselling, educational and personal enrichment classes, spousal employment assistance, information and referral, support for new parents, first aid/CPR, and other support efforts for military personnel and family members. The delegation received briefings, toured center, and visited with recent Philippine evacuees.

The delegation also visited child development, family advocacy, youth services and recreation programs operated by Army and Air Force Commands in Adak, Elmendorf Air Force Base, and Fort Wainwright, Alaska.

REPORTS ISSUED

Report of the Delegation Visit to Hawaii, Kwajalein, Guam, and Alaska - This report covers joint visit of the House Committee on

Armed Services Subcommittee on Military Installations and Facilities and the Select Committee to installations in isolated sites to assess the needs of military personnel and their families in the Pacific region and to review the situation in the Philippines in the wake of the eruption of Mt. Pinatubo. Summaries of delegation briefings on family issues such as housing needs, availability and affordability of child care, family support services and resources, and the special conditions associated with assignment to isolated posts are included.

Chairwoman's Report. A Plan of Action for Families: Response To A National Emergency - This report describes the increasing crisis facing American children and their families and successful, cost-effective programs that improve their health and well-being, and the Chairwoman's proposals to respond to the crisis by phasing-in full funding of successful programs and providing tax relief to families.

COMMITTEE HEARING SUMMARIES

and

FACT SHEETS

HEARING SUMMARY

RECLAIMING THE TAX CODE FOR AMERICAN FAMILIES

Washington, DC, April 15, 1991

On April 15, 1991, the Select Committee on Children, Youth, and Families conducted a hearing entitled "Reclaiming the Tax Code for American Families." The hearing discussed the increased tax burden on families since the end of World War II and examined approaches for reducing it.

Celinda Lake, Vice President, Greenberg/Lake, Washington, DC, reported that recent polling data indicate families have ongoing anxieties about the nation's economy and their ability to provide their children with the same benefits they had as children. The polls show that 82% of Americans expect their taxes to increase. Americans are disappointed in the 1986 tax reform package; more than one-half of those polled believe their taxes have gone up since 1986. According to Ms. Lake, between 63-75% of those polled think their income taxes are too high. She concluded by saying that the public is extremely wary about proposals to cut the social security payroll tax due to concern for the system's solvency when they retire.

C. Eugene Steuerle, Ph.D., Senior Fellow, The Urban Institute, Washington, DC, testified about how family tax burden has increased since World War II. In 1948, the $600 dependent exemption equalled 40% of per capita personal income, but by 1990, even though it had risen to $2,050, it was only 11% of per capita income. Had the exemption been indexed for inflation and real per capita income, it would be about $7,800 today. Social security tax rates have risen from 2% of earnings in 1948 to 15.3% in 1990. As a result, families with incomes one-half of median income, about $21,500, paid 2% of their income in total taxes in 1948 versus 23% today. Steuerle also testified that the lack of integration between the welfare and tax systems can lead to effective tax rates in excess of 90% for welfare recipients attempting to work their way off of welfare. Likewise, the marriage penalty tax for welfare recipients marrying a low- or even moderate-wage earner can reduce their income by more than 25%. He called for replacing the dependent exemption with a refundable child tax credit that would reduce welfare payments and help low-and moderate-wage earners. Steuerle felt that redressing the tax burden on families would require a multi-year effort, involving significant sums of money and large shifts in tax burdens and transfer payments.

Robert Shapiro, Ph.D., Vice President, Progressive Policy Institute, Washington, DC, testified that since 1973, young families with children in particular have lost economic ground or barely kept up. Real median family income stagnated from 1973 to 1988 while inflation-adjusted consumer debt rose by 17%, leaving families with smaller savings. At the same time, sharp increases in the social security payroll tax have more than offset any cuts in income tax rates for everyone but the rich. Shapiro called for reducing the tax burden on families by increasing the child exemption to reflect actual child-rearing costs -- which he estimates to be between $5,500 and $7,000 per year -- and phasing it down to the current level ($2,050) at higher incomes. He also recommended that single parents be granted the income tax filing status of married couples, instead of the current "head of household" status, which has a higher tax rate than married couples. Finally, he called for reducing the social security payroll tax and removing the "cap" that exempts income above $53,400.

Gary Bauer, President, Family Research Council, Washington, DC, also addressed the increasing tax burden on families. According to Bauer, the tax code is biased against middle-income families because the dependent exemption is worth more to upper-income families and lower-income families get tax relief through the Earned Income Tax Credit (EITC). Bauer also felt that the tax code discriminates against childrearing because the Dependent Care Tax Credit (DCTC) is available only to families with out-of-pocket child care expenses. He called for an increase in the dependent exemption, an expansion of the EITC's young child credit and a spousal EITC. The Family Research Council and the Heritage Foundation have jointly proposed a refundable per-child tax credit of $1,800 for preschool children and $1,200 for children ages six and older and a family wage supplement that would provide a larger supplement to two-parent families.

Timothy M. Smeeding, Ph.D., Project Director, Luxembourg Income Study and Professor of Economics and Public Administration, Metropolitan Studies Program, The Maxwell School, Syracuse University, Syracuse, NY, testified that industrialized countries rely on income transfer policies as well as tax codes to provide assistance to families with children. Tax and cash grant provisions in the United States are smaller relative to average wages than in other countries. In addition, in the U.S., these tax and grant provisions are tied to wages by means of a graduated percentage formula. Most other countries provide flat amounts of credit that are either tax exempt, or are counted as income for purposes of calculating taxes. Other western countries are also more generous in providing universal child allowances. Smeeding called for more generous universal tax and

transfer policies for families with children and full taxation of all transfer benefits as a means of paying for expanded benefits.

Heidi Brennan, Co-Executive Director, Mothers at Home, Vienna, VA, testified about recognizing the achievements of mothers who choose not to work outside of the home and for accomodating the needs of working mothers in the workplace. She called for flexible work policies including job sharing, flex-time, telecommuting, and the expansion of home-based businesses. Brennan felt that mothers' options regarding work are constrained by the tax code and that the erosion of the personal exemption has produced economic stress and a loss of freedom to families. She favored increasing the personal exemption to approximately $7,000 and transforming the Dependent Care Tax Credit into a universal young child credit.

Nancy Duff Campbell, J.D., Managing Attorney, National Women's Law Center, Washington, DC, described the rationale behind the Dependent Care Tax Credit (DCTC) and its dual role in providing government assistance to families in meeting their child care expenses and in equalizing the ability of families with the same income and family size to pay taxes. She noted that use of the DCTC has declined significantly as a result of changes in the tax code requiring taxpayers to provide the taxpayer identification number of their child care providers and social security numbers for their dependents. She noted that the DCTC is not indexed for inflation as are other basic provisions that determine tax liability. Thus, the value of the credit will continue to erode. Ms. Campbell recommended that the DCTC be maintained and made refundable, that it be indexed for inflation and that the credit should not be phased out at higher income levels.

* * * *

RECLAIMING THE TAX CODE FOR AMERICAN FAMILIES

A FACT SHEET

TAX BURDEN OF MIDDLE-INCOME FAMILIES CONTINUES TO INCREASE

- In 1990, federal, state, local and social security taxes accounted for 25% of median family income compared with 23% in 1970 and just 14% in 1960. (Progressive Policy Institute [PPI], 1990)

- In 1948, a median-income family of four paid only .3% of its income in federal taxes and 1.5% of earnings (up to $3,000) in social security taxes. By 1990, a median-income family of four paid about 9% of its income in federal taxes and 7.65% of earnings (up to $51,300) in social security taxes. (Committee on Ways and Means, U.S. House of Representatives, 1990; PPI, 1990)

- If the 1948 personal exemption had been adjusted for inflation, it would be equal to $3,000 today. If it were adjusted to reflect the same proportion of median income that it did in 1948, it would be the equivalent of $6,000. (PPI, 1990)

- Between 1977 and 1990, federal tax rates for the top 1% of taxpayers (average 1990 income $549,000) decreased 15%, while federal tax rates for middle-income taxpayers (average 1990 income $30,960) increased by more than 1% and for moderate-income families (average 1990 income $19,350) by 2%. (McIntyre, 1990)

- Since 1967, federal revenues raised from corporate income taxes have fallen from 4.3% of Gross National Product (GNP) to 1.7% in 1990. During the same time, revenues from individual income taxes increased from 7.7% of GNP to 8.6% and revenues from social security taxes increased from 4.1% to 7%. (Congressional Budget Office, 1991)

COST OF RAISING CHILDREN CONSUMES FAMILY RESOURCES

- The estimated costs of raising a child born in 1990 to age 17 are $151,170 for low-income families, $210,070 for middle-income families, and $293,400 for upper-income families. (U.S. Department of Agriculture, 1990)

- The median sales price for existing single-family homes nationwide rose from $23,000 in 1970 to $95,500. The cost of housing was significantly higher in the northeast and western regions of the country. (National Association of Realtors, 1990)

- In March 1990, 67% of all women with children under 18 were in the labor force. Families spend an estimated $15.5 billion annually on child care. (U.S. Bureau of the Census, 1990)

- By the year 2000, per capita spending on health care is projected to rise to $5,515, an increase of 443% from 1980. Families will

experience a 512% increase in out-of-pocket health care costs between 1980 and 2000, from $63 billion to $386 billion, not counting health insurance premiums. (Families USA, 1990)

- The cost of a college education continues to outpace inflation. In 1986/87, the average annual cost of postsecondary education ranged from $4,138 at a public institution to $10,039 at a private one. The comparable figures for 1976/77 were $1,935 and $3,977. (U.S. Department of Education, 1990)

FAMILY INCOMES DECLINE IN THE 1980s

- Between 1977 and 1990, middle-income families saw their real income decline by 6%. For moderate-income families, the drop was 9%. After-tax declines were even steeper, averaging an additional percentage point for each income group. (McIntyre, 1990)

- The median income for single-parent families fell 9% (from $15,210 to $13,620) between 1979 and 1987. (Congressional Research Service, 1990)

- Between 1973 and 1979, real median family income for young families (with a household head ages 25-34) grew by 2.9%, but fell 4.8% between 1979 and 1988. (Mishel, 1990)

FAMILIES BORROWING MORE MONEY TO MAKE ENDS MEET

- In 1988, the level of household debt relative to disposable income reached a post World War II high of 94%. (Pollin, 1990)

- Between 1970 and 1986, families with incomes less than $17,500 (in 1986 dollars) experienced the greatest relative increases in debt/income ratios. (Pollin, 1990)

April 15, 1991

HEARING SUMMARY

GENERATING INNOVATIVE STRATEGIES FOR HEALTHY INFANTS AND CHILDREN

Washington, D.C., April 23, 1991

The Select Committee on Children, Youth, and Families held a hearing to explore promising strategies that assist families in overcoming financial, institutional, and attitudinal barriers to obtaining early, comprehensive medical care and social services. Witnesses outlined successful efforts to coordinate service delivery through "one-stop shopping" models that include co-location of services, case management, home visiting, joint application forms, on-site presumptive eligibility determination for Medicaid, public-private partnerships, and other strategies to help families navigate highly fragmented health and social services systems.

The Honorable Bill Bradley, Member, U.S. Senate; Member, National Commission to Prevent Infant Mortality, released the Commission's report, "One-Stop Shopping: The Road to Healthy Mothers and Children," which highlights state and local efforts to provide coordinated health and social services. The Commission report broadly defines "one-stop shopping" as a strategy to help locate, enroll, support, motivate, educate, advocate, and provide services for pregnant women, mothers, and their families. Bradley recommended full funding for Maternal and Child Health (MCH) Block Grant programs, which would trigger demonstration grants for "one-stop shopping" efforts and home visiting programs, and offered four legislative proposals to improve access to prenatal and pediatric care, childhood immunization, the Special Supplemental Food Program for Women, Infants, and Children (WIC), and Head Start.

The Honorable Thomas J. Bliley, Jr., Member, U.S. House of Representatives, stressed the need to reduce the incidence of low birthweight and to prevent infant mortality. He discussed his strategy to harness $11.6 billion in federal and state funds to consolidate ten maternal and child health programs, including WIC, parts of Medicaid, the MCH Block Grant and the Title X Family Planning program into a block grant to states. His proposal would allow States to determine eligibility for services and require states to certify providers who must agree to deliver integrated out patient services to women, infants, and children in an integrated setting. In the process of consolidation, his legislation would repeal statutory authority for

WIC, Adolescent Family Life, and Title X Family Planning programs.

Robert Harmon, M.D., M.P.H., Administrator, Health Resources and Services Administration, U.S. Department of Health and Human Services, Rockville, MD, briefly discussed the Department's recent announcement to reorganize children's programs under one agency, the Administration for Children and Families, and highlighted the Administration's infant mortality initiative, called the Healthy Start Program. The infant mortality demonstration project aims to reduce the infant mortality rates in 10 communities by 50% over a five-year period. Participating communities will be required to demonstrate a commitment to increasing access to care, and to integrate a number of medical and social services such as outreach, home visiting, child care, case management, and family planning, according to locally defined needs. Congress recently appropriated $25 million for the pilot year of the Healthy Start project, and the Administration proposes $171 million for FY 1992. This request includes a direct appropriation of $139 million in new money, with the remainder coming from areas already concerned with infant mortality-related issues.

Maria Gomez, Executive Director, Mary's Center for Maternal and Child Care, Washington, DC, presented an overview of the "one-stop shopping" services provided by Mary's Center, a prenatal and pediatric care clinic which serves primarily undocumented Latino families who live in Washington, DC. The Center's bilingual staff includes certified nurse midwives, social workers, a pediatrician, and other medical personnel who offer care which reflects the cultural traditions of their patients. Services provided by Mary's Center include prenatal and well-baby care, counseling, parenting education, home visiting, pregnancy testing, and future planning. By co-managing clients with local hospitals and other social service agencies, Mary's Center helps its patients to receive WIC and Medicaid benefits, reduced cost or free pregnancy-related services, housing, employment, day care, legal assistance, and education.

Judith Jones, Associate Clinical Professor and Director, National Center for Children in Poverty, Columbia University School of Public Health, New York, NY, briefly reviewed the Center's recent report "Alive and Well? A Research and Policy Review of Health Programs for Poor Children," which documented the relationship between poverty and poor birth outcomes, increased illness, and increased mortality among America's poorest infants and young children. Jones also provided a historical review of the failure of the federal government's "limited scale" intervention strategy to deal with the

health and well-being of poor children. Jones noted that while co-location of services would be impossible in many locations, the nation's 600 community health centers offer a model of comprehensive health care for the poor and uninsured, often housing WIC, well-baby care, prenatal and pediatric care, and social services at one location. Jones also shared examples of how other local health programs have overcome institutional barriers to improving delivery of services to poor children and families. Jones offered three strategies for improving health services for low-income families: Existing services should be reorganized; unfriendly institutional practices should be changed; and the content and delivery of care should be modified to incorporate services of social workers, nutritionists, and public health nurses.

Kay Johnson, Senior Health Policy Advisor, March of Dimes Birth Defects Foundation, Washington, DC, outlined several recent studies that identify financial, systemic, and attitudinal barriers to comprehensive maternity and infant health care. She also identified several factors that contribute to improved access to preventive care, including accelerated, on-site eligibility procedures for Medicaid, WIC participation, outreach and public information campaigns.
The March of Dimes recommends: Mandating Medicaid coverage for pregnant women and infants up to 185% of poverty; increasing funds for the MCH Block Grant and Community and Migrant Health Centers in order to provide prenatal care in all medically underserved areas; full funding for WIC; providing additional drug treatment for pregnant women, including optional Medicaid funding for residential programs; and funding for "one-stop shopping" demonstrations as authorized in the MCH Block Grant, but never funded.

* * * *

GENERATING INNOVATIVE STRATEGIES FOR HEALTHY INFANTS AND CHILDREN

A FACT SHEET

INFANT DEATH RATE, PRENATAL CARE USE SHOW LITTLE OR NO PROGRESS

- In 1988, nearly 39,000 U.S. infants died before their first birthdays. The infant mortality rate (IMR) was 10.0 deaths per 1,000 live births. African-American infants were twice as likely to die than

white infants, with IMRs of 17.6 and 8.5 respectively. (National Center for Health Statistics [NCHS], 1990)

- Low birthweight is the greatest determinant of infant death and disability. In 1988, 6.9% of all infants were born at low birthweight (LBW), or less than 5.5 lbs., unchanged from the previous year. Among African-American births, the incidence of LBW was 13.0%, the highest level since 1976, compared with 5.6% of white births and 7% of births to Hispanic mothers. (NCHS, 1990)

- The proportion of mothers receiving early prenatal care has remained stagnant since 1979. In 1988, nearly one-fourth (24%) of babies was born to mothers who did not begin prenatal care in the critical first trimester. Among African-American mothers the rate was 39%. (NCHS, 1990)

COMPREHENSIVE/ACCESSIBLE PRENATAL CARE, NUTRITION CRUCIAL FOR HEALTHY DEVELOPMENT

- In a North Carolina study of 758 low-income women, pregnant women on Medicaid who received private practice physician care were 57% less likely to receive the benefits of the Special Supplemental Food Program for Women, Infants, and Children (WIC) and 2.3 times more likely to have a low birthweight baby than women who received prenatal care at the public health department's comprehensive care program. (Buescher, et al., 1987)

- In a study of over 21,000 North Carolina births to Medicaid recipients, women not receiving services coordinating maternity care had a low birthweight rate 17% higher and a neonatal mortality rate 39% higher than those receiving coordination services. (Select Committee on Children, Youth, and Families, U.S. House of Representatives, 1990)

- Pregnant women on Medicaid who are not WIC participants are 2-3 times more likely to receive inadequate prenatal care than those on both Medicaid and WIC. (Klerman, 1991)

- Prenatal participation in WIC is associated with Medicaid savings ranging from $1.77 to $3.13 for newborns and mothers for every WIC dollar expended. (U.S. Department of Agriculture, 1990)

HEARING SUMMARY

CLOSE TO HOME: COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN

Washington, DC, April 29, 1991

The Select Committee on Children, Youth, and Families held a hearing which examined the need for community-based care for children with serious mental disorders and explored innovative, cost-effective attempts to provide family-centered services for children with such needs.

The Honorable L. Douglas Wilder, Governor of the Commonwealth of Virginia, highlighted the State of Virginia's attempts to make the transition from an institutionally-based children's mental health system to a community-based one. The strategies for the transition include: 1) redirecting and pooling a percentage of funds that previously paid for residential care across four child-serving agencies; 2) allocating seed grants to five communities ready to make the transition; 3) establishing a public/private trust fund for the development of community services; and 4) allocating resources to localities through a single fund based on youth population and ability-to-pay factors. He recommended that action at the Federal level include allowing foster care funds to pay for services that prevent out-of-home placements.

Barbara Huff, Parent; and President, The Federation of Families for Children's Mental Health, Topeka, KS, is a parent of a child who suffered from a serious emotional disturbance, and also the organizer and president of the first parent support group in Kansas. She testified about the severe emotional and financial stress that her family has experienced, and the lack of treatment options and supportive services available to them. She described the anguish of being told that she had to relinquish custody of her child in order to obtain state-funded services. She called for a system of care that provides affordable, flexible, coordinated, and family-centered services for children in their home communities.

Lenore B. Behar, Ph.D., Special Assistant for Child and Family Services, North Carolina Department of Human Resources, Division of Mental Health, Developmental Disabilities and Substance Abuse, Office of Child and Family Services, Raleigh, NC, discussed two demonstration projects in North Carolina which are developing

community-based services for children with mental health problems. The first project is a 5-year, federal/state partnership that focuses on military children in the Fort Bragg catchment area. The project aims to provide a full continuum of child mental health services with emphasis on alternatives to inpatient and residential treatment. Dr. Behar testified that there was a great increase in the demand for mental health services for children during Project Desert Storm, but that hospitalizations declined during this period due to the availability of community-based alternatives. The second project is a Robert Wood Johnson demonstration project in a rural area that focuses on seriously disturbed children who are at risk for out of home placement. This project shows that, even when population is sparse and distances are great, it is possible to coordinate and tailor mental health and related services.

Sandra Cornelius, Ph.D., President-Elect, Elwyn, Inc., Elwyn, PA, testified about her experiences as former Director of Human Services for the Delaware County Government in Pennsylvania, where she oversaw child welfare, mental health, juvenile detention and daycare programming. She discussed her frustration with public dollars that served only a few of those in need because only expensive inpatient services were offered. She also reported frustration with having to negotiate eligibility for federal dollars in different categorical programs when a single family had multiple needs.

Dr. Cornelius was instrumental in obtaining a Robert Wood Johnson demonstration project grant to demonstrate the relative cost-effectiveness of community-based care. She pointed to the need for additional funding while institutional care is phased out. She strongly recommended that the Federal government encourage private insurance companies to pay for in-home services and other non-institutional care.

Clifford Attkisson, Ph.D., Professor of Medical Psychology, Department of Psychiatry, University of California, San Francisco, CA, discussed research underway evaluating the **California Model System of Care** in three California counties. The California model, designed to create service plans and case management procedures, and integrates services related to mental health care, social services, education, and juvenile justice. Dr. Attkisson cited progress towards reduced reliance on restrictive levels of care, prevention of out-of-home placements, maintenance of progressive educational achievement, and reduction of recidivism in the juvenile justice system. He estimated that, if the California Model System of Care had been instituted in all counties in California, the State could have

saved $170 million over two years in the cost of group homes alone. Dr. Attkisson called for support of training for researchers in the area of children's mental health services, and more support for research.

Dixie Jordan, Parent Advocacy Coalition for Educational Rights (PACER), Minneapolis MN, a Native-American woman whose 18 year-old son has suffered from bouts of suicidal depression for many years, urged Congress to make mental health services more accessible and more sensitive to cultural factors. She explained that the role of racism is ignored in prevalent models of mental illness, and that too many behaviors are being given disease labels. Based on her work with numerous families, Ms. Jordan described divorces and separations resulting from the great stress of dealing with a disabled child. She said that she was never asked what support would be needed to care for her child at home, and feels that many so-called "dysfunctional families" are families at their wits' end for lack of professional guidance.

George A. Rekers, Ph.D., Professor of Neuropsychiatry and Behavioral Science, University of South Carolina School of Medicine, Columbia, SC, suggested that "intact" families are the major source of healthy children, and, conversely, that dysfunctional or single-parent families produce emotional disturbance in children. He urged the involvement of the family in a child's therapy, explained that non-traditional families must have compensating supports to fill necessary traditional roles, and recommended that the government support research and programming that help families build on strengths so that they can remain intact.

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CLOSE TO HOME: COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN

A FACT SHEET

MILLIONS OF CHILDREN SUFFER FROM MENTAL HEALTH PROBLEMS

- At least 7.5 million children (12% of those under 18) have diagnosable psychological disorders. Nearly half of them are severely disabled by their mental health problems. (U.S. Department of Health and Human Services [DHHS], 1990)

- Conduct disorders (characterized by symptoms such as verbal and physical aggression, anti-social behavior, and poor impulse control that are often associated with delinquent behavior) affect up to 5.5% of the child population. (Friedman, 1990)

- The suicide rate for young people ages 15 to 24 has nearly tripled during the past 30 years. Suicide is now the third leading cause of death for this age group. (Office of Technology Assessment [OTA], 1991; National Center for Health Statistics, 1991)

MENTAL HEALTH PROBLEMS CONTRIBUTE TO RUNNING AWAY AND HOMELESSNESS AMONG YOUTH

- Four out of five runaway youth suffer from depression, in contrast to 24% of non-runaway youth. Eighteen percent of runaway youth have attempted suicide, and an equal number have other serious mental health problems. (Yates, et al., 1988)

- Forty percent of runaway and homeless youth said that emotional conflict at home was a factor in their decision to leave home. (U.S. Government Accounting Office, 1989)

CHILDREN'S MENTAL HEALTH NEEDS ARE LARGELY UNMET BY EXISTING CHILD-SERVING SYSTEMS

- Only about 1 in 5 children who need mental health treatment receives it. (DHHS, 1990)

- When states were ranked by consumer advocates according to the quality of services they provide for seriously emotionally disturbed children, only Vermont, Ohio, New York, North Carolina, Maine and Alaska received as high a rating as 3 points out of a possible 5. (Torrey, et al., 1990)

- Only 30% of school children with behavioral and emotional disorders are identified and receive services under the Education of the Handicapped Act. In 1988, there was a 16.5% shortage of special education teachers for children with emotional disturbances. (Knitzer, 1990; U.S. Department of Education, 1990)

- Youth in juvenile detention facilities suffer clinical depression at almost three times the rate of other adolescents, and suicide occurs more than twice as frequently among detained youth.

Many facilities offer only emergency mental health services rather than ongoing treatment. (American Medical Association Council on Scientific Affairs, 1990)

- A recent study of all Medi-Cal eligible children in California found that those in foster care were five times more likely to be hospitalized for mental health problems than other eligible children. But early intervention and treatment are rare; one study of black children in foster care found that 41% of those ages 6 to 12 and 80% of those under age 5 have not had mental health evaluations. (Halfon, et al., 1990; National Black Child Development Institute, 1989)

THOUSANDS OF CHILDREN ARE PLACED IN RESTRICTIVE SETTINGS, OFTEN INAPPROPRIATELY

- An estimated 50% of youth in residential treatment receive care that is inappropriate for their situation. (DHHS, 1990)

- In a 1986 survey, 37 states reported that 4,000 children were placed in out-of-state mental health facilities at an estimated cost of $215 million. In addition, 22,472 children were treated in state hospitals, often in remote locations, despite the demonstrated effectiveness of community-based programs. (National Mental Health Association [NMHA], 1989)

- Residential treatment of children has risen dramatically over the past several decades. Admission rates of youth in private psychiatric hospitals increased by 1,327% between 1971 and 1985. By contrast, private admission rates for those over 18 increased by only 32%. (Lerman, 1990)

- Children and youth represent the largest proportion of those under care in private psychiatric hospitals (41%). However, patients under 18 constitute relatively low percentages of inpatients served in multi-service mental health organizations (16%), in state and county mental hospitals (6%), and in general hospitals (6%). (DHHS, 1990)

- There are few community-based programs for adolescents with mental health problems. Consequently, adolescents are hospitalized for less serious mental health problems (e.g., non-dependent drug use) and spend more days in the hospital than young adults. (Butts & Schwartz, in press)

TOO FEW PROFESSIONALS SPECIALIZE IN CHILDREN'S NEEDS

- There are shortages in every subfield of children's mental health research, and many childhood mental health disorders are not adequately understood. Child psychiatry represents an extreme example of the recruitment problem; fewer than 100 academic child psychiatrists devote 30% or more of their time to research. (DHHS, 1990)

- Of the $13.8 million the National Institute of Mental Health budgets for training grants, less than one fourth is awarded to programs specializing in services for children. (Magrab & Wohlford, 1990)

ACCESS TO SERVICES LIMITED BY INADEQUATE INSURANCE

- In 1986, only half of adolescents' outpatient visits to mental health settings were covered by commercial health insurance or Medicaid. (OTA, 1991)

- Private insurance often covers only inpatient mental health treatment. The lack of alternative service coverage is evidenced by the finding that length of stay in residential treatment was longer for youth with private insurance than for those who paid any other way. (Butts & Schwartz, in press)

FEDERAL SUPPORT FOR CHILDREN'S MENTAL HEALTH SERVICES LIMITED

- By law, 10% of each state's Alcohol, Drug and Mental Services block grant funds are to be set aside for mental health services for children, but reports of actual expenditures are not required. As a result, the proportion of funds spent as intended is unknown. (Office of Treatment Improvement, 1991)

- Medicaid funding for community-based mental health services for children is very uneven. Most states have used the Rehabilitation, Clinic or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) options to reimburse some services, and one state has negotiated a difficult-to-obtain waiver to reimburse this kind of care. (Fox, 1990)

April 29, 1991

HEARING SUMMARY

ON THE FRONT LINES: POLICE STRESS AND FAMILY WELL-BEING

Washington, DC, May 20, 1991

A recent hearing of the Select Committee on Children, Youth, and Families examined the stress of police work and its impact on the well-being of police families. Witnesses testified that the high levels of stress associated with police work can contribute to a range of serious family problems, including family violence, but that few police departments offer comprehensive assistance to help police families cope with stress. Witnesses further described several types of psychological and family support programs which offer a range of services to officers and their families.

Gary W. Sommers, Sergeant, Training Services, Prince George's County Police Department, Landover, MD (accompanied by Mrs. Kay Sommers), a police officer who accidentally shot and killed his partner in the midst of a drug raid three years ago, described his depression and the problems that he and his family experienced after the accident. Over the two years following the accident, Sommers, his wife, their parents, the deceased officer's family, and other officers and their families were counseled by the department's psychologist. Sommers testified that, without the department's program, his law enforcement career and marriage might have ended.

Ellen Scrivner, Ph.D., Director, Psychological Services Division, Prince George's County Police Department, Upper Marlboro, MD; and President Elect, Division of Psychologists in Public Service, The American Psychological Association, Washington, DC, profiled factors in police work that can cause family disruption, including rotating shifts, risk of injury and death, and public and departmental pressures. She documented the slow growth in police psychological services, the minimal attention given to police family needs, and the need for more research. She also described the Prince George's County Police Psychological Services Division and its services to families, that include counseling, 24 hour emergency response, and support groups.

Cathy Riggs, Former Police Officer, Santa Rosa Police Department; Wife of U.S. Representative Frank Riggs (former police officer), Santa Rosa, CA, testified that shift changes and irregular work hours make it difficult for police officers to spend time with their families. She

described how exposure to the victimization of human beings can produce traumatic effects in officers and cause distance between officers and their families. Riggs advocated stress management training and counseling for recruits, officers, and their families. She recommended that officers exercise and that police families become involved in community groups, such as Little League baseball, Big Brothers/Big Sisters, and churches.

Leanor Boulin Johnson, Ph.D., Associate Professor of Family Studies, Department of Family Resources and Human Development, Arizona State University, Tempe, AZ, presented results of a study which examined the relationship between officer stress and family problems among East Coast police officers and their spouses. The study found that police families experience high levels of stress and burnout and use ineffective coping strategies. 40% of officers surveyed reported that, in the previous six-month period, they had behaved violently toward their spouse or children. Boulin Johnson called for research and services which address the influence of job burnout on spouse interaction and potential for divorce, the effects of officer interaction, and the needs of police children.

Beverly J. Anderson, MA, CAC, Clinical Director/Program Administrator, The Metropolitan Police Employee Assistance Program, Washington, DC, (accompanied by Jeffrey A. King, Officer and Peer Counselor Coordinator, The Metropolitan Police Employee Assistance Program, Washington, DC), described police officers as being prone to suppression of emotion, anger, post-shooting trauma, depression, psychosomatic illness, anxiety, hypervigilance, suicide attempts, and food, sexual, and nicotine addictions. She explained that the resulting stress within police families can result in a wide range of problems, including family violence, divorce, communication breakdowns, and other problems. Anderson highlighted the services offered by the District of Columbia Metropolitan Police Employee Assistance Program. These services include marital and adolescent support groups, stress management training, long-term counseling, suicide and post-shooting debriefing, and peer counseling.

King testified that police work and officers' frequent encounters with human misery can have a damaging effect on police families. He described his six-year service as a police officer, which includes drug undercover work and three shootings, and his experience as the son of a police officer who experienced great on-the-job stress. King described how the peer counseling program which he directs assists officers by identifying problems and providing crisis intervention.

Aristedes W. Zavaras, Chief, Denver Police Department, DC, testified that the authority to kill another human being takes a great toll on police officers and adds to the serious stressors affecting police families. He described the psychological and peer counseling programs available to Denver police officers. Zavaras also estimated that the Denver Police Department invests approximately $60,000 in each recruit and that, by the time an officer has spent a few years on the job, this figure is doubled. He asserted that police departments cannot afford not to provide services which support officers and prolong their careers. Zavaras stated that smaller police departments, often located in rural and suburban areas, generally have no services for police families.

Anthony E. Daniels, Assistant Director, Training Division, Federal Bureau of Investigation, Quantico, VA (accompanied by James T. Reese, Ph.D., Supervisory Special Agent, Assistant Unit Chief, Behavioral Science Services Unit, Training Division, Federal Bureau of Investigation, Quantico, VA), outlined the psychological and employee assistance services offered to Federal Bureau of Investigation agents, including access to a consulting psychologist, peer counseling, and a critical incident trauma program. He also described the role that the FBI has played in police stress education. The FBI has held national and world symposia on police psychological services, conducted seminars on police stress for officers and family members, and established the primary national referral network of police psychologists.

Reese told the Committee that police officers often show an emotionless "image armor" in order to endure the human suffering and public exposure that they encounter each day. He stated that, when police officers bring their work-related stress home, the family may suffer communication breakdowns and more serious problems. Reese argued that a strong need exists in most police departments for changes in shift rotation policy, better education for family members, the creation of police spouse and family organizations, and greater availability of psychological services.

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ON THE FRONT LINES:
POLICE STRESS AND FAMILY WELL-BEING

A FACT SHEET

PSYCHOLOGICAL AND SUPPORT SERVICES FOR POLICE AND THEIR FAMILIES GROW DURING 1980s, BUT TODAY'S DEMAND FAR EXCEEDS SUPPLY

- In a 1979 survey of police departments nationwide, only 20% used some type of psychological services, compared with more than half of all departments surveyed in 1988. (Delprino and Bahn, 1988)

- In a national survey of 232 large municipal and state police departments, 53% provided counseling to police officers for job-related stress, 52% provided counseling to officers for personal and family problems, and 42% counseled police officers' spouses and family members. However, the perceived need among departments for these specific counseling programs was 79%, 72%, and 64% respectively. (Delprino and Bahn, 1988)

- In a study of 188 police departments where an officer had died feloniously or accidentally, 54% had a psychological unit, but only 31% offered access to a staff psychologist. Only 5.4% of the departments offered peer counseling and police family response services, 43% made counseling referrals, and 19% paid for outside counseling. Surviving relatives of police officers killed in the line of duty reported a lack of psychological counseling for family members, and feelings of abandonment by the police departments. Nearly 70% of departments surveyed lacked formal policies concerning the death of an officer, including assistance to the families of the slain officer. (Stillman, 1987)

POLICE STRESS UNDERMINES OFFICER AND FAMILY WELL-BEING

- In a 1988 Arizona study of 553 police officers and their spouses, 41% of male officers and 34% of female officers reported violent assaults in their marital relationships compared with 16% of civilians. Over one-third of wives of police officers (37%) reported violence in their marriage. (Neidig, Russell, and Seng, unpublished)

- A 1981 survey of Toronto police officers found a divorce and separation rate of 63%, almost double the national average among Canadians at the time. Recent studies indicate that as many as 75% of police marriages in large metropolitan areas are likely to end in divorce. (Came, et al., 1989)

- A study of 130 California police officers and their spouses found that job burnout is associated with domestic, emotional, and behavioral problems. Yet only 10% of the officers sought counseling or support while 80% of their spouses did. (Maslach and Jackson, 1979)

- Between 1980 and 1981, applications filed for disability pensions at the Los Angeles Police Department (LAPD) increased 82%. Of the 104 disability pensions granted during 1981, 63% were stress or psychologically related. While stress-reduction and mental health programs and more stringent claim evaluations reduced the LAPD's stress-related disability pensions to seven in 1988, 25% were stress-related in 1990, the highest proportion since the mid-1980s, when the rules on psychiatric-related petitions were first tightened. (Petrone and Reiser, 1985; Hackett, et al., 1989; Los Angeles Times, 1991)

- In a study of 82 Honolulu undercover officers, 28% experienced relationship and marital problems and 20% experienced excessive use of alcohol during their undercover assignment. (U.S. Department of Justice [DOJ], 1986)

- A 1986 review suggested that as many as 30% of all police officers abuse alcohol, compared with less than 10% of the population at large. (Hepp, 1987)

INCREASED VIOLENT CRIMES PUT OFFICERS AT EVEN GREATER RISK

- In 1990, violent crimes such as murder, rape, robbery and aggravated assault increased by 10%, the largest annual increase since 1986. (Federal Bureau of Investigation, 1991)

- Violent crimes increased 43% during the decade from 1977 to 1987. During the same time period, the average rate of serious violent and property crimes reported to police departments in large cities increased 22%. (DOJ, 1987)

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- In 1989, almost 22,000 law enforcement officers were injured as a result of line-of-duty assaults, 79 police officers were accidentally killed while on official duty and 66 law enforcement officers were feloniously killed. (Uniform Crime Reports, 1989)

- In a 1986 nationwide training needs assessment, state and local law enforcement officers in all types and sizes of agencies ranked the need for training in personal stress management as the highest priority. (DOJ, 1986)

May 20, 1991

HEARING SUMMARY

BABIES AND BRIEFCASES: CREATING A FAMILY-FRIENDLY WORKPLACE FOR FATHERS

Washington, DC, June 11, 1991

On June 11, 1991, the Select Committee on Children, Youth, and Families conducted a hearing entitled "Babies and Briefcases: Creating a Family-Friendly Workplace for Fathers." The hearing explored the important role fathers play in parenting their children, what corporations are doing to create work environments that support fathers, and how to change the "corporate culture" that inhibits fathers from taking advantage of available family policies and programs.

Gordon Rothman, Field Producer, CBS News, New York, NY, a father currently on paternity leave from his job at CBS News, testified about the positive impact that his leave has had on him and his family. His leave, coupled with his wife's, allowed their baby daughter to spend her first six months with her parents. He noted that three elements made his leave possible: (1) a company policy that allows parental leave; (2) a supportive attitude on the part of his colleagues and supervisors, and (3) adequate financial resources to be able to take advantage of unpaid leave.

Beverly King, Director of Human Resources, City of Los Angeles Department of Water and Power, Los Angeles, CA, described the "family-friendly" programs and policies that the Department of Water and Power has in place for its workforce, which is 78% male. The programs include on-site and near-site child care centers that enroll more than 500 children, expectant parent classes, parent support groups, dependent care spending accounts, a beeper alert program for expectant fathers and parents of high-risk children, a lactation program for nursing mothers and feeding coaching programs for fathers, family leave policies, including a job guarantee for up to four months. King reported that these programs have proven to be extremely cost-effective, returning $2.50 for every $1.00 invested.

James A. Levine, Director, The Fatherhood Project, Families and Work Institute, New York, NY, demonstrated how easy it is to overlook the fact that men in the labor force are fathers, too. He noted that no one talks about "working fathers." His research indicates that fathers are increasingly experiencing conflicts between their work and family responsibilities, similar to those of working

mothers. From 1977 to 1989, the number of men reporting a significant conflict between work and family life increased from 12% to 72%. Because fathers sense that the "corporate culture" doesn't allow them to be explicit about their parenting responsibilities, many resort to subterfuge when leaving work early. Levine noted that it is one thing to have a policy in place, but quite another to have a "corporate culture" that enables men to take advantage of those policies. Levine advocated for a policy of support through passage of the Family and Medical Leave Act, the adoption of more flexible workplaces, and the inclusion of fathers in discussions about "family-friendly" work policies.

Lynn O'Rourke Hayes, Co-author, "The Best Jobs in America for Parents," Chevy Chase, MD, testified that workplace flexibility is critical to reducing the stress that parents endure when trying to balance their work and family responsibilities. She cited studies indicating that parents would be willing to trade "rapid career growth" to spend more time with their families. Among the flexible workplace policies that she encouraged employers to adopt were job sharing, compressed work weeks, extended work weeks, flexible schedules, flextime, and part-time work (she indicated that "shortened hours" or "shortened work week" might have less stigma attached to them). As employers become more flexible, they realize the benefits that accrue: reduced employee replacement costs due to less turnover, increased productivity, more employee loyalty, reduced absenteeism, added recruitment power, and improved morale.

Norma Radin, Professor of Social Work, The University of Michigan, Ann Arbor, MI, reported findings from her longitudinal study of families where fathers were the primary early caregivers. Her most recent findings indicate that adolescents who were raised in such environments as young children hold less traditional views of their own future career paths. The researchers concluded from their data that these children are more adapted to their future lives than are their peers from more traditional families. Dr. Radin also summarized other research on the specific impact of fathers on their children and noted that studies indicate that boys' intellectual development is enhanced by greater involvement with their fathers and that proficiency in mathematics is related to a father's presence. A 26-year longitudinal study reported that one of the best predictors of being able to express empathy in adulthood was the amount of paternal involvement in child care. Dr. Radin encouraged the support of employment practices that encourage men to be active participants in their children's upbringing.

Myriam Miedzian, Ph.D., author, "Boys Will Be Boys: Breaking the Link Between Masculinity and Violence", testified that her research indicates that the absence of nurturing fathers from parenting leads to increased rates of male violence. She noted that between 1960 and 1987, the percentage of children born to single mothers nearly tripled and violence rates rose by 85%. According to Miedzian, research suggests that boys who lack a male role model may develop an obsessive need to prove their masculinity. This "hypermasculinity" can lead to violent behavior. In contrast, she testified, boys raised by nurturing, caring fathers model themselves on their fathers and learn to be caring and empathetic. Dr. Miedzian concluded that the benefits of nurturing by fathers include: A new model of masculinity that embraces caring and empathy; reduced male violence and lower crime rates, and an improved quality of mothering. She recommended childrearing classes for young children and teenagers as a means of encouraging more nurturing fathers.

William R. Mattox, Jr., Director of Policy Analysis, Family Research Council, Washington, DC, presented suggestions for government policymakers and employers interested in fostering more "father-friendly" workplaces. Policies should encourage parents to spend more time with their children. Fathers should be encouraged to balance their work and family responsibilities over the life cycle. Mattox noted that not all families in which both parents work need paid child care and that employee benefit plans that provide paid parental leave and child care may penalize employees who don't need these services. Maddox testified in support of increased wages and flexible work arrangements to help families as opposed to "service-oriented" benefits, such as on-site child care. He also encouraged support for mothers at home and more work-at-home options for fathers.

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BABIES AND BRIEFCASES: CREATING A FAMILY-FRIENDLY WORKPLACE FOR FATHERS

A FACT SHEET

WORKING FATHERS STRUGGLE TO BALANCE WORK AND FAMILY

- In March, 1990, 24.4 million fathers -- 36% of all males in the labor force -- had children under the age of 18. Two-thirds of them had wives in the labor force. Twelve million working fathers

FATHERS' INVOLVEMENT IN FAMILY LIFE ENHANCES CHILDREN'S WELL-BEING

- A study of teenagers from two-parent families whose fathers played a large role in their childrearing indicated that older teens tended to have a more flexible outlook toward sex roles in general than younger teens. All of the teens held less traditional views of their future employment patterns and their future child care plans. (Radin, 1991)

- A study of highly involved fathers indicated that their children had greater verbal competence. Proficiency in mathematics is also related to the father's presence. (Radin, 1981, 1991)

- A 26-year longitudinal study that tracked young children into adulthood found that the amount of time a father spends with a child is one of the strongest predictors of empathy in adulthood. (Koestner, Weinberger and Franz, 1990)

- Teenagers from two-parent families reported that they experienced more enjoyment and were more satisfied when involved in activities with fathers than with their mothers. When leisure time was shared with parents, adolescents spent proportionately more time with their fathers. (Montemayor and Brownlee, 1987)

EMPLOYER RESPONSE TO FAMILY RESPONSIBILITIES IS MIXED

- A survey of 188 of the country's largest corporations indicates that **all** of them offered some family-friendly policies, including maternity leave, part-time work options, Employee Assistance Programs, and/or counseling on work-family issues. Two-thirds of these companies were considering implementing new family-friendly policies at the time of the poll. (Families and Work Institute, 1991)

- The BLS Employee Benefits Survey of medium and large private employers indicates that in 1989: 5% of employees had access to employer assistance for child care; 3% had access to elder care assistance; 11% had access to flextime; 37% had access to unpaid maternity leave; 3% had access to paid maternity leave; 18% had access to unpaid paternity leave and 1% had access to paid paternity leave. (BLS, 1990)

- A survey of Fortune 500 companies indicated that 37% of those polled provided for an unpaid parenting leave with a job guarantee to men. Ninety percent of those companies offering leaves to fathers called them "personal leave" and made no attempt to inform employees that such leave was available to new fathers. (Catalyst, 1986)

- A 1986 poll of Fortune 500 companies of employer attitudes towards fathers taking leave revealed that 63% of the respondents felt "no leave" was reasonable. Nearly half of the companies that offered leave to fathers (41%) considered "no length of time reasonable." (Catalyst, 1986)

June 11, 1991

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OPTIONS FOR EMPLOYERS
FAMILY-ORIENTED PROGRAMS AND POLICIES

Family-oriented work policies come in all sizes and shapes. The list of options presented below is meant to provide a sample of options that some employers have already instituted.

CHANGING THE CORPORATE CULTURE: MAKING THE WORKPLACE FAMILY-FRIENDLY

1. Establish a work and family committee or task force
2. Assess employee needs through surveys or focus groups
3. Provide flexibility in work hours and other policies to meet the individual needs of employees
4. Communicate policies in writing and through staff development programs
5. Train managers and supervisors to be sensitive to work/family issues
6. Designate a work and family program manager

WORK TIME/PLACE OPTIONS

1. Flextime
2. Compressed work week
3. Part-time employment (with pro-rated benefits)

4. Job sharing
5. Overtime flexibility
6. Flexiplace: Telecommuting and/or work at home

COUNSELING PROGRAM OPTIONS

1. Employee assistance programs (alcohol/drug abuse counseling and/or treatment programs; family counseling)
2. Stress reduction seminars
3. Relocation assistance for working spouses of employees

CHILD CARE OPTIONS

1. On-site child care center
2. Near-site child care center
3. Contract for slots in existing child care centers
4. Information and referral assistance for locating child care
5. Recruitment and training of family day care providers
6. Funds or other support for extended hours at near-site child care centers for employees who work extended hours or evening/night shifts
7. Emergency child care services; care for mildly ill children
8. Transportation to after-school recreation/child care programs
9. Help with start-up costs for outside child care center
10. Vouchers or direct subsidies to employees
11. Child care handbook to assist employees in locating child care best suited to their needs
12. Summer camp program

LEAVE OPTIONS

1. Flexible vacation options
2. Use of sick leave to care for sick immediate family members
3. Personal leave - specific amount (paid)
4. Personal leave - flexible (unpaid)
5. Paid parental leave
6. Extended unpaid parental leave (job-guarantee; continuing benefits)
7. Return from parental leave on part-time basis
8. Leave bank (annual and/or sick leave)
9. Flexible leave for teacher conferences or other school events
10. Bereavement leave

11. Nursing breaks

INFORMATION/SEMINAR OPTIONS

1. Employee orientation programs that include information on family-supportive policies and programs, management training programs, strategic plans and annual reports
2. Elder care counseling and referral services
3. Parenting seminars
4. Parent support groups
5. Computer bulletin board information exchange
6. New parent seminars
7. Parent resource center with books, videos, and magazines on parenting, child care and caring for the elderly

TELEPHONE ACCESS OPTIONS

1. Telephone for routine/emergency family calls
2. "Short" long distance calls for family emergencies
3. Calling home from business trips

FINANCIAL SUPPORT OPTIONS

1. Flexible benefit plans (Dependent Care Assistance Plans)
2. Health insurance for dependents
3. Reimbursement for adoption expenses
4. Tuition assistance
5. Scholarship programs for employees' children
6. Reimbursement for extra child care costs for travel or overtime work
7. Employee financial assistance fund for financial crises

MISCELLANEOUS OPTIONS

1. Develop children-at-work policies (for snow days; other emergencies)
2. Address family concerns in recruitment interviews
3. Make uneven career paths acceptable
4. Curtail anti-nepotism rules
5. Postpone relocation for family reasons
6. Support family picnics/holiday events

7. Provide nursing space
8. Join/start employer network
9. Encourage developers to include child care in space where you rent

Adapted from "Family-Oriented Policy and Program Options for Employers," prepared by Jean D. Linehan, The Bureau of National Affairs, Inc.

HEARING SUMMARY

THE RISKY BUSINESS OF ADOLESCENCE: HOW TO HELP TEENS STAY SAFE - Parts I and II

Washington, DC, June 17-18, 1991

The Select Committee on Children, Youth, and Families recently held two hearings to examine the behaviors and circumstances that put adolescents at risk of too-early childbearing, drug abuse, AIDS, and other sexually transmitted diseases. The hearings investigated the prevalence of adolescent risk-taking and the need for comprehensive prevention efforts for both in-school and out-of-school youth. Common strategies highlighted by witnesses included: training youth in social and peer resistance skills; involving parents, peers educators and schools; preparing youth for the labor force; and working with community agencies to provide resources and to reinforce prevention messages.

Part I

William Gardner, Ph.D., M. Stat., Associate Professor of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, PA, provided evidence that thousands of American adolescents become infected with HIV each year and that current HIV prevention efforts with adolescents are failing because they have been limited to "one-shot" efforts to provide information, rather than long-term programs to provide youth with the skills they need to change risky behaviors. Gardner recommended that prevention programs should be introduced before risk-taking behaviors begin and that interventions should address the relationships between sexual activity and drug use. Gardner testified that youth who are at greatest risk (gay adolescents, runaways, youth in areas of concentrated urban poverty, and delinquent adolescents) require intensive, individualized and targeted efforts. Gardner called for increased basic research on adolescent sexual behavior and expanded funding for research-based prevention services for youth who are difficult to reach through traditional school or public health interventions.

Lloyd J. Kolbe, Ph.D., Director, Division of Adolescent and School Health (DASH), Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control (CDC), Atlanta, GA, outlined CDC's efforts to assess the health risks facing America's youth and to implement national programs that promote adolescent health and prevent risk-taking behavior. Kolbe described the CDC Youth Risk

Behavior Surveillance System which is used by federal and state policy makers to design prevention programs. Kolbe testified about the importance of comprehensive, skills-based K-12 school health curricula, noting that numerous studies have shown that planned, sequential, and age-appropriate health education in schools can be effective in reducing the prevalence of health risk behaviors. Kolbe announced CDC plans to fund demonstration programs in three large cities to facilitate the integration of health and social services for youth in high-risk situations.

Mary Jane Rotheram-Borus, Ph.D., Associate Professor, Division of Child Psychiatry, Columbia University, New York, NY, described an intensive HIV/AIDS prevention program serving 450 runaway and gay male adolescents in New York City. Participants in the model program receive comprehensive health care services and access to community resources and 15 or more sessions designed to develop skills and social support for behavior change. After six months, participants are significantly more likely to report increased consistent condom use and decreased patterns of high-risk sexual behavior, compared with youth who receive only 2-3 hours of educational intervention. Rotheram-Borus called for widespread dissemination of model HIV preventive services, providing comprehensive care to HIV-positive adolescents, adequate funding for temporary residential and long-term independent living programs, prospective studies of HIV testing and counseling procedures tailored to adolescents, increased support for impoverished and dysfunctional families, and expanded specialized intervention programs for gay, sexually-abused, and substance-abusing youth.

Linda Dianne Meloy, M.D., FAAP, Assistant Professor of Pediatrics, Department of Pediatrics, Children's Medical Center, Medical College of Virginia, Virginia Commonwealth University, Richmond, VA, testified that despite current federal prevention efforts, adolescents are facing increased risks of sexually transmitted diseases, pregnancy, and unhealthy development. Meloy argued that abstinence is the most effective means of preventing emotional and physical distress caused by these medical problems, and recommended that adolescents have access to comprehensive medical care. Meloy believes that pediatric offices provide the optimal "medical home" where adolescents can obtain medical care, counseling, and learn about prevention.

Lenore Zedosky, Assistant Director, Office of Educational Support Services, West Virginia Department of Education, Charleston, WV, accompanied by Rae Ellen McKee, 1991 National Teacher of the Year, Pointe, West Virginia, testified about the dissemination of a comprehensive K-12 school-based health program to all schools in the

state of West Virginia. Zedosky outlined various developmentally-based components of the curriculum and stressed the important contributions that parents and community leaders can play in integrating school programs with existing services in the community. Ms. McKee described the importance of addressing the health care needs of students so that they can learn.

Dorothy Wodraska, Assistant Director, Project I-STAR (Indiana Students Taught Awareness and Resistance), Inc., Indianapolis, IN, described the history and implementation of this comprehensive, community-wide drug prevention program. Project I-STAR includes a curriculum for students in middle/junior high school, a parent education component, research, media involvement, and community organizing to create an environment that deters youth from using alcohol and other drugs. A longitudinal study involving 12,000 students showed that students who did not participate in the I-STAR program were 25% more likely to increase their use of marijuana and 21% more likely to increase their use of alcohol than students who did participate. Project I-STAR and the Kansas City STAR program are part of the Midwestern Prevention Project developed and directed by the Institute for Health Promotion and Disease Prevention Research at the University of Southern California.

Jose Duran, M.C.P., Executive Director, Hispanic Office of Evaluation and Planning (HOPE), Boston, MA, described the design and implementation of a comprehensive community-based program to provide HIV education, prevention, and support care to Latino families. Duran recommended that prevention programs for Latino youth should: communicate clear and explicit information, instill a sense of cultural pride, involve peer leaders and parents, and be bilingual. Duran called for increased funding for community-based organizations for prevention and services, improved training of minority researchers and health care providers, and additional resources to help racial and ethnic communities to overcome the socio-economic and other barriers to preventive and primary health care.

Kathleen M. Sullivan, Director, Project Respect, Golf, IL, described her abstinence education program and the results of a pre-and post-test evaluation of the program. Participants were found to be more likely than control students to report changes in attitudes about sexual decisions. Sullivan also testified that among project participants, there was a strong correlation between sexual activity and alcohol and other drug use. Sullivan called for increased funding for abstinence programs.

Part II

Secrets Cast, Kaiser Permanente Mid-Atlantic States Region, Washington, DC, performed an excerpt of "Secrets," an educational theater presentation that has been touring junior and senior high schools in six regions of the country since 1989. "Secrets" is intended to increase student awareness of HIV and its transmission, and reduce apprehension and prejudice arising from misinformation surrounding AIDS. Following the performance, the cast told the Committee that "Secrets" had been performed over 1,000 times to 614,000 students to date. The cast further discussed the importance of answering questions after each school performance, as an opportunity for "peer counseling" with the audience.

Eleshia Ray, Kianga Stroud, and Nkenge Toure, Peer Educators and Youth Coordinator, PEERS Program, Terrific Inc., Washington, DC, described their program which trains youth ages 13-19 to help peers prevent teen pregnancy, HIV, other STDs, and drug use. Peer educators receive training in leadership development and communication skills as well as content relevant to prevention work. Peer educators provide workshops in a variety of community settings, and utilize media and other strategies to communicate their messages, including role playing, videos, rap, straight talk, radio, and cable television. Ms. Toure provided suggestions to parents about how to help their children make informed decisions about sexuality.

Robert Selverstone, Ph.D., President, Board of Directors, Sex Education and Information Council of the U.S., (SEICUS), Westport, CT, described his work to help parents and adolescents to communicate more openly about issues related to sexuality. Stating that parents are, and ought to be, the primary sexuality educators of their children, Selverstone identified five major barriers to parent-child communication, including lack of appropriate vocabulary, embarrassment about insufficient knowledge, fear of confrontation over values, belief that sexuality is a private topic, and poor listening and other communication skills. Selverstone recommended that all children and youth receive comprehensive K-12 sexuality education and called for increased sexuality education and training for families, teachers, religious leaders, and youth-serving agencies.

Gil Walker, Commissioner, Chicago Housing Authority (CHA), The Midnight Basketball League, Chicago, IL, accompanied by Butrell Selph, League participant, described the establishment of the Midnight Basketball League as part of a comprehensive anti-crime strategy undertaken by CHA. The league serves 160-200 young men ages

17-25 who are unemployed and who have not completed high school. Players receive job training and life skills courses, in addition to coaching, athletic equipment, and community acclaim. Teams are sponsored by local businesses which provide employment opportunities and mentoring to players. In the three years of operation, no player has been arrested, many have obtained full time employment or high school equivalency diplomas, and some are now attending classes at a local community college. Mr. Selph described how his participation in the league has improved his self-esteem and social development.

John Lyons, Ph.D., Associate Professor of Psychiatry, Psychology, and Medicine, Northwestern University Medical School, Chicago, IL, described a literature search he performed to evaluate the impact of school-based clinics on teen pregnancy rates. Lyons identified 34 empirical studies, including 26 that discussed pregnancy and contraception issues and services. Among the studies identified in his search, Lyons found little evidence that school-based clinics reduce, delay, or stimulate sexual activity, but found that they do increase adolescents' knowledge of and access to contraceptives. Some research showed that teens who attend the clinics use contraception more often. Lyons stated that school-based clinics should provide a range of services including immunization, vision and hearing screening, and counseling services, but that the evaluations he identified had focussed on the role of school-based clinics in pregnancy prevention.

Bronwyn Mayden, Executive Director, Governor's Council on Adolescent Pregnancy, Baltimore, MD, accompanied by Cathy Cardall, parent of Governor's Council teen advisory board member, outlined the strategies of the Governor's Council to reduce teen pregnancy rates. Mayden described a public/ private multi-media campaign that focusses on male responsibility and the costs of raising children, efforts to increase teen access to contraception, including a statewide "Three for Free" condom distribution campaign, and the Parents and Children Talking (PACT!) campaign. Mayden also highlighted an after-school enrichment program in the state's poorest county that targets teens who engage in high-risk sexual and drug behavior. Ms. Cardall testified that her daughter's participation in a Governor's Council teen advisory board has enhanced her ability to make informed decisions about sexuality.

Bradley P. Hayton, Ph.D., Public Policy Research Manager, Focus on the Family, Pomona, CA, concluded from correlational research that "condom-based sex education programs" increase teen pregnancy and abortion rates, premarital sexual activity, and sexually transmitted diseases, and lower academic performance and aspirations. According to Hayton, some studies show delayed sexual activity in "more religious

adolescents" and that children from large families are less sexually active. Hayton called for policies that "support the traditional family and teach traditional values such as abstinence before marriage."

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THE RISKY BUSINESS OF ADOLESCENCE: HOW TO HELP TEENS STAY SAFE

A FACT SHEET

DRUGS, PREGNANCY, HIV, AND OTHER STDs THREATEN HEALTH OF MILLIONS OF YOUTH

- Eight million junior and senior high school students (nearly 40% of this population) report weekly consumption of alcohol, including 5.4 million students who have "binged" with five or more drinks in a row, and 454,000 who report an average weekly consumption of 15 drinks. (U.S. Department of Health and Human Services [DHHS], 1991)

- In 1989, 91% of graduating high school seniors reported having consumed alcohol, 44% had used marijuana, 19% had used stimulants, 18% had used inhalants, 10% had used cocaine, and 9% reported having used hallucinogens. (National Institute of Drug Abuse, 1990)

- Approximately 1.1 million teenage girls become pregnant every year. In 1988, nearly 489,000 babies were born to girls under age 20 and the birth rate for girls ages 15-17 was at its highest level since 1977 with 33.8 births per 1,000 population. (DHHS, 1990; National Center for Health Statistics, 1990)

- Of AIDS cases reported in the U.S. by April 30, 1991, one in five was among young adults in their twenties. The average latency period between HIV infection and AIDS diagnosis is eight to ten years, therefore, many young adults probably were infected as adolescents. The total number of AIDS cases reported among persons ages 13-24 increased by 75% between 1989 and 1990. (Centers for Disease Control [CDC], 1991)

- Three million teens are infected with a sexually transmitted disease (STD) annually. Nearly two-thirds (63%) of all STD cases occur among persons under 25 years of age. Adolescents have higher rates of gonorrhea and chlamydia than any other age group. Left

untreated, these diseases may lead to pelvic inflammatory disease which can cause infertility or fetal loss. (CDC, 1991; American Social Health Association, 1991)

SEXUAL ACTIVITY INCREASES AMONG TEENS; MANY ARE UNPROTECTED AGAINST PREGNANCY AND STDs

- An estimated 78% of adolescent girls and 86% of adolescent boys have engaged in sexual intercourse by age 20. Among girls ages 15-19, 53% were sexually active in 1988, compared with 47% in 1982. Much of this rise is associated with increased sexual activity among white and non-poor females. Among boys under age 19, the percent who were sexually active increased from 78% in 1979 to 88% in 1988. (DHHS, 1990; Darroch Forrest and Singh, 1990; Sonenstein, et al., 1989)

- The percent of U.S. teen girls practicing contraception rose between 1982 and 1988 from 24% to 32%. Nevertheless, in 1988, more than one-third (35%) of girls ages 15-19 reported no method of contraception at first intercourse and 82% of pregnancies among teenage girls were unintended, compared with 78% in 1982. Among never-married males living in metropolitan areas, 58% reported condom use at last intercourse in 1988. (Moser, 1990; Darroch Forrest and Singh, 1990; Sonenstein, et al., 1989)

- A study of 222 African-American teenage crack users found that 96% were sexually active, 62% had sold crack, 51% had combined crack use and sex, 41% reported a history of STDs, and 25% had exchanged sexual favors for drugs or money. While the average age of first intercourse was 12.8 years among the study population, the age at first condom use was 14.8 years. (Fullilove, et al., 1989)

COSTS OF DRUGS, STDs, PREGNANCY, AND HIV ARE STAGGERING

- Between 1985 and 1989, approximately 40,600 youth ages 15-24 died in alcohol-related motor vehicle accidents. (CDC, 1991)

- The aggregate annual costs of herpes, gonorrhea, chlamydia, and pelvic inflammatory disease are estimated to total $8.4 billion. (CDC, 1991)

- In 1988, families started by teen parents cost an estimated $19.83

billion in AFDC (Aid to Families with Dependent Children) payments, Medicaid, and food stamp outlays. If every birth to a teen mother had been delayed, an estimated $7.93 billion would have been saved. Federal funding for family planning services decreased by 39% between 1981 and 1991, adjusting for inflation. (Center for Population Options [CPO], 1990)

- The estimated health care expenditures for a typical AIDS patient from diagnosis to death range from $55,000 to $80,000. By 1992, the projected annual costs of AIDS are as high as $13 billion, not including treatment with expanded use of specific antiviral drugs, such as zidovudine (AZT) for asymptomatic HIV infected people. (Congressional Research Service, 1990; DHHS, 1990)

FORMIDABLE BARRIERS TO PREVENTING HIGH-RISK BEHAVIOR AMONG YOUTH REMAIN

- Approximately 4.6 million adolescents lack public or private health insurance, including nearly one-third of all poor adolescents. Of the estimated 21.7 million adolescents who are covered by private health insurance, one-third are not covered for maternity-related services by their parents' insurance. (Office of Technology Assessment, 1991)

- Fewer than half (47%) of sexually active teens surveyed reported having talked with their parents about sex and birth control. Nearly six in ten (58%) of sexually active teens who have discussed both of these issues with their parents report consistent use of birth control, compared with 16% of sexually active teens who have talked with their parents about sex but not contraception. (CPO, 1990)

- A 1989 survey of over 4,000 public school teachers who provide sex education found that while 75% believed that a wide range of topics related to the prevention of pregnancy and infection should be taught before the end of the seventh grade, only 35% reported that sex education was provided in grades 7 and 8. Virtually all teachers (97%) felt that sex education classes should include information about how students can obtain birth control, but only 48% were in schools where this was done. (Darroch Forrest and Silverman, 1989)

- During the 1988-89 school year, two-thirds of school districts nationwide required that HIV education be provided at some time for students in grades 7-12. Only 15% of school districts provided HIV education in grades 11-12, although rates of sexual activity are

known to increase markedly during this period. One-fifth of HIV teachers reported having received no specialized training in the subject. (Government Accounting Office, 1990)

COMPREHENSIVE, INTEGRATED SKILL-BASED PREVENTION PROGRAMS SHOW RESULTS

- A recent analysis of 100 programs that were successful in reducing high-risk behaviors among youth found several common strategies: Intense one-on-one individual attention; social skills training; involvement of parents, peer educators, and schools; preparation for entering the labor force; and community-wide, multi-agency approaches to provide resources and reinforce messages. (Dryfoos, 1990)

- Participants in a comprehensive drug abuse prevention program for students in grades 6-7 were at least 50% less likely than students in a control group to use cigarettes, alcohol, or marijuana one year after the study. Parents of participating students were more likely to report reduced alcohol use and increased physical activity. The program supplemented peer pressure resistance skills training with parental involvement, community organization training, and promotion of local health policy change. (Pentz, et al., 1989)

- An integrated rural school and community-based family planning program in South Carolina targeting adolescents, parents, and teachers in graduate training yielded a 56% reduction in the estimated adolescent pregnancy rate. (Vincent, et al., 1989)

- Initial data from a study of 144 gay and bisexual youth indicated that 83% did not know that HIV can be transmitted during oral sex, 75% engaged in unprotected rectal intercourse and/or needle sharing, and 18% were chemically dependent. After participating for three months in a model prevention program which included an initial assessment, individual risk reduction counseling, peer education, and referral to psychosocial services, self-reported consistent condom use rose sharply (from 44% to 73%) and participants were significantly less likely to report oral sex and symptoms of dysfunctional substance abuse. (Remafedi, 1990)

June 17-18, 1991

Tips for Parents about How to Talk to Children About Sex

1. Parents are the primary sexuality educators of their children, and should begin to talk with them about this natural part of life when they are very young. Children want to discuss these issues with their parents and want to hear their values. Do some thinking ahead so you know what you want to say about your feelings and attitudes. Your children look to you as a model, and your values provide them with valuable guidelines for making choices.[a]

2. The most important step you can take is to say the first words. Children do not always ask questions about sexuality, so you must begin.[a]

3. Try to answer your children's questions as they come up. It is never a good idea to tell children that they need to wait until they are older before you will answer their questions.[a]

4. Let your children know that they can always ask you any questions they may have.[a]

5. Teens need to know that sex will never hold a troubled relationship together. Fear of being alone is not a good reason to have sex.[b]

6. Let them know that decisions about sex should not be based on what others do, but on one's own feelings. Sex won't make anyone popular or feel better about himself or herself.[b]

7. Don't make the assumption that sex is your teen's major concern, or that sexual thoughts are only about intercourse. Tell your kids that thinking about sex is normal and that you know thinking about something is not the same as doing it.[b]

8. Adolescents crave privacy, but that doesn't mean they don't want you to be involved in their lives. Show that you are interested without demanding intimate details. Teens need to know you trust them.[b]

9. It's important for you to be honest. If you don't think your teenager is ready for a sexual relationship, say so and explain why. Teens need more than "just say no."[b]

10. Tell it like it is. Avoid fables, vague explanations, and

untruths when talking about conception or birth.[c]

11. Give simple explanations. Use appropriate names for parts and functions of the body. Children need a language to use when talking about their feelings, ideas and concerns.[c]

12. Get to know your child's environment. Current jokes, the TV and news programs they're watching, their music -- these will provide unlimited opportunities to discuss sexuality issues.[c]

13. Separate the child from the behavior. If your child does something inappropriate, label the behavior inappropriate, not the child bad.[c]

14. Sexuality education doesn't mean teaching kids how to have sex -- sexuality is about body image, gender roles, feelings about oneself that carry into adult relationships, as well as reproduction.[c]

15. Build up your children's self-esteem. Recognize their talents, personalities and accomplishments, and avoid comparing them with others. Reassure your youngsters -- especially when they're going through puberty -- that they are normal. A strong sense of self-worth helps determine the kind of choices they will make, sexual choices as well as other important life choices. Children who feel good about themselves are less susceptible to peer pressure and better equipped to make responsible decisions.[d]

16. Don't be afraid of not being an expert. If you don't know the answer, admit it, and then find out. Or you and your child can find the answer together by sitting down with a book.[d]

17. Educate yourself about HIV/AIDS and other sexually transmitted diseases, and make sure your children have the information they need to protect themselves. For example, they should know that latex condoms with nonoxyl-9 spermicide are much more effective than other types of condoms.[a]

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[a] How to Talk to Your Children About AIDS, (1989) Sex Information and Education Council of the U.S. (SIECUS), New York, University, New York, New York.

[b] Talking With Your Teenager About Sexual Responsibility, (1989) ETR Associates, Santa Cruz, California.

[c] A Guide for Parents and Kids, Talking Together About Sexuality, Governor's Council on Adolescent Pregnancy, Baltimore, Maryland.

[d] How to Talk To Your Child About Sexuality, (1990) Planned Parenthood, New York, New York.

HEARING SUMMARY

TURN IT DOWN: EFFECTS OF NOISE ON HEARING LOSS IN CHILDREN AND YOUTH

Washington, DC, July 22, 1991

On July 22, 1991, the Select Committee on Children, Youth, and Families conducted a hearing entitled "Turn it Down: Effects of Noise on Hearing Loss in Children and Youth." The hearing explored the causes of noise-induced hearing loss (NIHL) in children and teenagers, with a particular focus on the use of personal stereos. The hearing examined strategies to reduce the risks associated with leisure activities that produce dangerously loud sounds. Witnesses highlighted educational programs designed to teach children and teenagers about preventing hearing loss.

James B. Snow, Jr., M.D., Director, National Institute on Deafness and Other Communication Disorders (NIDCD), National Institutes of Health, Bethesda, MD, testified that, of the 28 million Americans who are hearing impaired, 10 million of them suffer from NIHL. He explained the causes and symptoms of NIHL and noted that noise can begin to damage hearing between ages 10 and 20. According to Snow, NIHL is permanent, but preventable. Gunfire, hammering, electric motors, lawn mowers, chain saws, snowmobiles and aircraft are examples of hazards to unprotected ears. NIDCD currently is funding research to examine hair cell changes in the ear due to intense sound and the disappearance of hair cells as a result of exposure to more intense and prolonged noise. Snow also discussed NIDCD's upcoming education campaign, "I Love What I Hear," targeted to 3rd through 6th grade children. He indicated that NIDCD hopes to reach young people ages 10-20 with the message that they should protect their hearing by avoiding exposure to loud noise, or by wearing ear protection. Snow encouraged the public to avoid exposure to dangerous noise, protect children, and use ear plugs when undertaking noisy activities.

Paul R. Kileny, Ph.D., Associate Professor and Director, Division of Audiology and Electrophysiology, University of Michigan Medical Center, Ann Arbor, MI, demonstrated the noise levels of several common household items, including personal stereos, a vacuum cleaner, and a "boom box." Kileny stated that personal stereos are not inherently hazardous to hearing, but because of their portable nature and their high maximum sound outputs, they are potentially dangerous if used over a period of time. Kileny recently tested 35 personal stereos and found that maximum output levels ranged from 115 to 126

decibels, levels considered hazardous to hearing with prolonged use. Kileny testified that with the large number of personal stereos in use today, he expects a significant increase in the hearing-impaired population over the next 10 to 20 years. Kileny recommended that the Environmental Protection Agency enforce the product noise labeling provisions of the Noise Control Act of 1972, that personal stereos have volume-limiting devices, and that national public information programs be established.

Jeff Baxter, Musician and Record Producer, Beverly Hills, CA, described the technological advances in audio reproduction over the past few years. He stated that sound reproduction technology is not inherently bad, but that education and awareness about its safe use are important. Baxter testified that children and young people should be taught to protect their hearing just as they are taught to protect their vision. He is the spokesperson for the House Ear Institute's Hearing is Priceless (HIP) campaign, which teaches high school students about hearing preservation. Baxter noted that he has worn headphones during live performances to protect his hearing for the past 15 years because of his desire to enjoy future audio technological advances. He concluded by saying we need to learn as much as possible about what causes hearing loss and how to protect hearing, and he emphasized the importance of passing this information on to teenagers.

Patrick E. Brookhouser, M.D., Director, Boys Town National Research Hospital and Father Flannigan Professor and Chairman, Department of Otolaryngology and Human Communication, Creighton University School of Medicine, Omaha, NE, testified that more than 20 million Americans, including children and adolescents, are exposed to hazardous sound levels on a regular basis, which can cause permanent damage to the ear over a period of time. His study of 114 children and adolescents with NIHL found that more than one-third of those with hearing loss in both ears identified fireworks or firearms as the primary source, as did 67% of those with hearing loss in one ear. Live or amplified music was the principal cause in 12% of the cases. Brookhouser noted that the number of household and leisure time devices capable of producing potentially damaging noise continues to increase. He recommended consumer product labeling, enforcement of existing federal laws regarding hazardous noise, additional federal, state and local legislative and regulatory attention, and community education efforts to deal with this preventable public health problem.

William W. Clark, Ph.D., Senior Research Scientist, Central Institute for the Deaf, St. Louis, MO, stated that a lifetime of environmental noise contributes significantly to the hearing problems of America's

older generation. Clark testified that NIHL can be prevented by understanding its sources, avoiding or limiting exposure to such noise, and by wearing effective hearing protection during noisy activities. Clark stated that hearing loss due to personal stereos depends on the volume level selected by the listener, the amount of time spent listening, the pattern of listening behavior, the susceptibility of the individual's ear to noise damage, and other noisy activities that contribute to the individual's lifetime dose of noise. Clark reported that a middle-class elementary school survey revealed that 80% of the children owned or used personal stereos at least occasionally. He maintained that 5-10% of those who regularly listen to personal stereos do so at dangerous levels and for durations long enough to present a hazard, and up to 20% of users experience symptoms that indicate temporary NIHL. Clark recommended that manufacturers of personal stereo units provide a warning on the unit that describes the symptoms of hearing loss and warns against exposures that produce those symptoms. He also suggested that volume controls be painted red for settings that exceed 90 dB.

Howard E. "Rocky" Stone, Chief Executive Officer and Executive Director, Self Help for Hard of Hearing People, Inc. (SHHH), Bethesda, MD, accompanied by Stephanie M. House, Staff Coordinator, SHHH, described his organization's innovative hearing conservation program targeted to elementary school children. The key component of this project is a "stoplight," which can be placed in the noisiest part of a school building or moved to different locations within a school. The "stoplight" remains green while the sound levels are acceptable, flashes yellow as a warning that noise is approaching the danger level, and turns red when an excessive sound level has been reached. The traffic light serves two purposes: it brings about a reduced noise level and it provides a noise standard for the children to use in other situations. The program, currently in use in 23 states, also provides additional educational materials to teachers and includes a number of visual aids.

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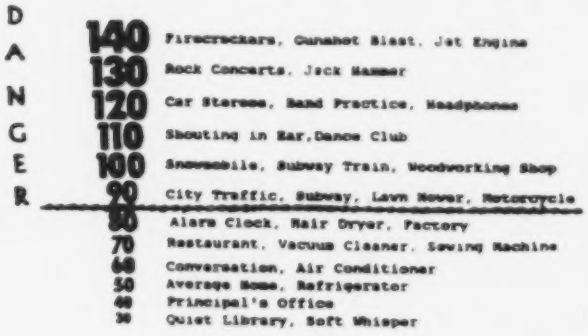
TURN IT DOWN: EFFECTS OF NOISE ON HEARING LOSS IN CHILDREN AND YOUTH

A FACT SHEET

LOUD NOISES SIGNAL DANGER

DECIBELS (dB)[1]


DANGER
140 Firecrackers, Gunshot Blast, Jet Engine
130 Rock Concerts, Jack Hammer
120 Car Stereos, Band Practice, Headphones
110 Shouting in Ear, Dance Club
100 Snowmobile, Subway Train, Woodworking Shop
90 City Traffic, Subway, Lawn Mower, Motorcycle
80 Alarm Clock, Hair Dryer, Factory
70 Restaurant, Vacuum Cleaner, Sewing Machine
60 Conversation, Air Conditioner
50 Average Home, Refrigerator
40 Principal's Office
30 Quiet Library, Soft Whisper

MILLIONS ARE HEARING IMPAIRED/NOISE RESPONSIBLE FOR LARGE PERCENTAGE

- Over 8% of the U.S. population have a hearing impairment, including 1.6% (1 million) under age 18 and 4.8% for those ages 18-44. Of the 28 million cases of hearing loss in the U.S., over 1/3 (10 million) are partially or fully attributable to noise-induced hearing loss (NIHL). (U.S. Public Health Service, 1989; National Institutes of Health, 1990)

- According to the Annual Survey of Hearing Impaired Children and Youth, 50.1% of hearing impairments among students derived from unknown causes. The remaining proportion derived from known causes, including heredity (13.3%), meningitis (9.0%), infection and fever (4.9%), and prematurity (4.7%). (Gallaudet University, 1990)

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[1] Sound levels above 85 decibels (dB) are potentially hazardous. Decibel increases are logarithmic, so 90 dB is 10 times as loud as 80 dB, and 110 dB is 20 times as loud as 90 dB.

CHILDREN AND TEENS FREQUENTLY EXPOSED TO HAZARDOUS NOISE LEVELS

- A survey of 1500 Ohio high school students found considerable exposure to potentially damaging levels of noise. Respondents reported use of personal stereos with headphones (72%), stereos (96%), dances (71%), rock concerts (43%), tractor pulls (27%), and firearms (30%). (Lewis, 1989)

- According to a university-based study, the following toys emitted hazardous noise levels at close range: toy robots and cars (82-100 dB), toy sirens and drills (74-102 dB), squeaky toys (78-108 dB), and firecrackers (126-156 dB). Additional studies found that many toys held directly to the ear can emit up to 120 dB, and that toy pistols can emit in excess of 150 dB. (Axelsson and Jerson, 1985; Fay, 1989; Clark 1991)

- The average sound level measured at a New Kids on the Block concert was 98 dB (164% of the Occupational Safety and Health Administration allowable dose) and levels routinely rose above 100 dB. Earlier generations of concert amplifiers were in the 20,000 to 30,000 watt range; current large concert speakers are equipped with 100,000 to 500,000 watt amplifiers. (Clark, 1991; Brookhouser, et al., 1991)

- A study of noise exposure among players of electronic arcade games found that normal noise settings ranged from 73 to 111 dB. (Plakke, 1983)

LOUD NOISES CAUSE HEARING LOSS AND OTHER PROBLEMS FOR CHILDREN

- In a study of 94 diagnosed cases of NIHL in children and adolescents, the following causes were identified: fireworks or firearms (46%), live or amplified music (12%), power tools (8%), and recreational vehicles (4%). (Brookhouser, et al., 1991)

- In a Connecticut study of 20 adolescents and 7 adults attending a school dance with amplified music, all but two experienced at least a 5 dB temporary hearing loss and all but one reported tinnitus (ringing of the ears). Of those re-tested three days later, two-thirds demonstrated only partial recovery. (Danenberg, et al., 1987)

- A study examining children attending elementary schools near a busy

metropolitan airport found that children from these noisy schools had higher blood pressure, were more likely to fail on a cognitive task, and were more likely to give up on an assigned task than were children from quiet schools. (Cohen, et al., 1980)

- A study of 538 teenage boys found that they were routinely exposed to hazardous sound levels during daily activities; 15% showed hearing loss in high frequencies. (Axelsson, et al., 1981)

- A Wisconsin study found that over half of children actively involved in farm work experienced NIHL, twice the rate of their peers not involved in farm work. (Broste, et al., 1989)

PERSONAL STEREO USE POSES SPECIAL HAZARDS TO YOUNG PEOPLE

- At least 80% of children in a middle class elementary school owned or used personal stereos at least occasionally. Other surveys indicate a range from 37% of school children ages 11-18 in England to 81% of children attending youth clubs in Hong Kong. One study revealed that personal stereo use among young people increased significantly with age -- 9 to 11 years (10%), 13 to 16 years (12%), and 18 to 25 years (35%). (Clark, 1991; Fearn and Hanson, 1984)

- A British study concluded that young people ages 15-23 who regularly use personal stereos and attend concerts suffered hearing loss at twice the rate of young people without such exposure. The study revealed diminished sensitivity to sound and reduced ability to discriminate between pitches. (West and Evans, 1990)

- A study of personal stereo use by teenagers asked participants to listen to music at an enjoyable level for one hour; the mean temporary hearing loss was 9 dB with a maximum up to 35 dB. (Hellstrom and Axelsson, 1988)

- Maximum output levels of 35 personal stereos were found to range from 115 to 126 dB SPL (sound pressure level). When participants listened to personal stereos at a comfortable volume, levels ranged from 83 to 107 dB SPL. A study of 18 personal stereos found that, at one-half volume, the units emitted an average of 104 dB playing rock music and 102 dB playing easy listening music. (Kileny, unpublished; Rintelmann, unpublished)

- In a survey of 89 personal stereo users, 31% reported listening

levels which exceeded OSHA risk standards; of this group, half exceeded the Auditory Risk Criteria limit by more than 100%. Another survey of 750 personal stereo users found that one-fifth reported symptoms of tinnitus or dullness of hearing after using their devices. (Catalano and Levin, 1985; Rice, Rossi, and Olina, 1987)

EXERCISE, ALCOHOL, AND SMOKING WORSEN EFFECTS OF NOISE ON HEARING LOSS

- Studies suggest that those who listen to loud music while doing aerobic exercises, which increase blood flow to the extremities, decrease oxygen around the ear, and increase the flow of adrenalin, may be at additional risk of suffering some hearing loss. (Navarro, 1989)

- A 1987 study found that smoking is associated with increased risk of hearing loss in a noise-exposed population. (Barone, et al., 1987)

- Alcohol consumption can increase the amount of noise needed to trigger the acoustic reflex (which protects the ear by reducing sound intensity) by 5-13 dB. (Robinette, et al., 1981)

HEARING LOSS PREVENTION SUCCESSFUL, BUT IN SHORT SUPPLY

- An education hearing conservation program presented to normal hearing elementary school children improved knowledge about NIHL by an average of 23%. A pre-program survey found that only 6% of the children reported use of ear protection; following the program, 97% intended to use ear protection during noisy activities. (Chermak and Peters-McCarthy, 1991)

- Following a high school hearing conservation program in West Virginia, students' correct responses to hearing-related questions improved by nearly one fifth. (Lass, et al., 1986)

- In a survey of Ohio high school students, only 61% of questions regarding hearing loss and protection were answered correctly. In a study of adult hearing health knowledge, participants had correct responses to only 52% of the test items. (Lewis, 1989; Singer and Brownell, 1984)

- In a survey of industrial arts teachers, over half reported that they had no background in hearing conservation. Two-thirds felt that they needed more background in this area. (Plakke, 1985)

July 22, 1991

HEARING SUMMARY

CHILD ABUSE TREATMENT AND PREVENTION IN THE 1990s: KEEPING OLD PROMISES, MEETING NEW DEMANDS

Denver, Colorado, September 15, 1991

On September 15, 1991, the Select Committee on Children, Youth, and Families held a hearing entitled, "Child Abuse Treatment and Prevention in the 1990s: Keeping Old Promises, Meeting New Demands." Held in conjunction with the Ninth Annual Conference on Child Abuse and Neglect in Denver, Colorado, the hearing investigated the effects of child abuse and neglect and identified Federal, state, and local solutions to the problem.

Marilyn Van Derbur Atler, Former Miss America and Incest Survivor, Denver, CO, described the sexual violations she endured from age 5 to age 18 and the impact it has had on her life. She spoke about her shame and fear of telling anyone what was happening. Van Derbur Atler said that she wasn't afraid of her father, she was terrified of him. She explained that children don't tell because they are threatened, beaten, terrorized, and traumatized. She also stated that, "Most children know if they DO tell, they will not be believed." In Van Derbur Atler's compelling testimony, she said, "It is disheartening for me to state that for me, in my family, I believe nothing would be different if I were a child today than it was for me in the 1940s." She also said, "We cannot expect children to speak up until adults have had the courage to speak up and make the path easier and safer for them." Van Derbur Atler made a plea for other sexual abuse victims and recommended the use of Public Service Announcements, to spread the message that violating a child is wrong, and to intimidate and stop perpetrators.

Wade Horn, Ph.D., Commissioner, Administration for Children, Youth, and Families, U.S. Department of Health and Human Services, Washington, DC, accompanied by **David Lloyd, Director, National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services, Washington, DC**, testified that the appropriate role for the Federal government in child abuse and neglect efforts was to provide leadership, knowledge building, and targeted support of state and local initiatives. He noted that the Secretary of Health and Human Services, Dr. Louis Sullivan, has made the fight against child abuse and neglect a priority for the entire Department. He also asserted that creating major new Federal programs, prior to the conduct of adequate research and evaluation would be premature and

could result in the misdirection of resources. Horn recommended that the Federal Government stimulate policies targeted and designed to foster parental choice and empowerment.

Richard Krugman, M.D., Chairman, Advisory Board on Child Abuse and Neglect, U.S. Department of Health and Human Services, Washington, DC; and Director, C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, CO, officially released the U.S. Advisory Board on Child Abuse and Neglect's second annual report, "Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Neglect." Krugman discussed the Board's finding that the Federal response to child abuse and neglect is fragmented, inadequate, and often misdirected. He stated that, "Federal policy has focused on investigation more than prevention and treatment," and described the current system of response to child abuse and neglect by state and county governments as "overwhelmed and on the verge of collapse." Krugman highlighted several of the report's recommendations including enacting a national child protection policy; developing a universal neonatal home visitation program; establishing and strengthening Federal child protection programs; eliminating the use of corporal punishment of children in federally supported activities; and mobilizing schools and religious institutions in the prevention of child maltreatment.

David Espinoza, Executive Director, La Causa Family Center, Milwaukee, WI, described the Milwaukee Child Abuse Prevention Network which is a collaboration of agencies committed to bringing prevention programs to the inner city. One program supported by the Network is the La Causa Family Center which is the first crisis nursery in Milwaukee County. The Family Center provides support to parents and children during times of crisis or emergencies. Espinoza explained that the crisis nursery provides temporary shelter for children and crisis intervention counseling in English and Spanish. The Family Center serves two multi-ethnic communities and Espinoza emphasized the importance of providing culturally competent services. He also noted that the local child protective services agency had a decrease in reports of child abuse and neglect since the inception of the crisis nursery program. Espinoza attributes program effectiveness to the many community agencies that successfully collaborate to prevent abuse and keep families together.

Cresson Carrasco, Parent-Infant Psychotherapist, Community Infant Project, Mental Health Center of Boulder County, Boulder, CO, described the Community Infant Project, which provides comprehensive

home visitation services to high-risk families. Carrasco presented evaluation data showing that instances of confirmed physical abuse recorded by the State Department of Social Services were twice as frequent in at-risk families not served by the program. She also shared the results of a cost comparative study of a family that received the Community Infant Project (CIP) compared with a family that was involved with the Department of Social Services (DSS). The average monthly cost of services for the CIP family was $162 compared with $2032 for the DSS family.

Barry Bennett, Program Director, Innovative Treatment Programs, Division of Adult, Child, and Family Services, Iowa Department of Human Services, Des Moines, IA, outlined the Iowa Decategorization Project, which blends Federal, state, and local funding streams into one child welfare fund. This pooling of funds allows more community-based, family-centered, and placement-prevention oriented services. Project outcomes include: An increase in less restrictive and family-centered interventions; reductions in foster care placements and spending; and development of new treatment services such as family preservation, therapeutic foster care, adolescent day treatment and parent education programs. Bennett recommended that the Federal government offer greater incentives to states to encourage development of family preservation, family reunification, and aftercare programs, as well as funding for innovative demonstration projects similar to their decategorization project.

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CHILD ABUSE PREVENTION AND TREATMENT IN THE 1990s: KEEPING OLD PROMISES, MEETING NEW DEMANDS

A FACT SHEET

MILLIONS OF YOUNG CHILDREN ABUSED EACH YEAR

- In 1990, there were more than 2.5 million reports of child abuse, an increase of more than 30% since 1985 and 100% since 1980. (National Committee for Prevention of Child Abuse [NCPCA], 1991)

- Estimates of national child abuse and neglect substantiation rates vary from 35% to 53%. In 1987, there were 700,000 substantiated

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cases, up from more than 400,000 cases in 1980.[1] American Association for Protecting Children, 1991)

- A 1990 state survey of child maltreatment indicated that 27% of reported abuse cases were due to physical abuse, 46% to neglect, 15% to sexual abuse, and 13% to emotional maltreatment or other (abandonment and dependency). (NCPCA, 1991)

- In 26 of the responding states, an average of 95% of the victims knew their perpetrators. Less than 2% of reported abuse cases took place in a foster care or child care setting. (NCPCA, 1991)

CHILD ABUSE INCREASINGLY CLAIMS THE LIVES OF VERY YOUNG CHILDREN

- In 1990, an estimated 1,211 children from 39 states died from abuse or neglect, a 38% increase nationwide since 1985. Almost 90% of children who died as a result of abuse or neglect were under age 5; 53% were infants under age one. (NCPCA, 1991)

- Homicide as a cause of children's death in the Western world is almost uniquely a U.S. phenomenon. In the U.S., homicide is the leading cause of death from injury before age one. Among boys ages 1 to 4, the homicide rate (2.6 deaths per 100,000 children) is more than twice the highest rate in Europe (1.2 in Belgium). (Miller, 1991)

COLORADO CHILDREN SUFFER HIGH RATES OF ABUSE

- In 1989, there were 7,224 confirmed victims of child abuse and neglect in Colorado, a decrease of 4% from the previous year. Between 1987 and 1988, however, child abuse reports increased 24%. Of confirmed reports, 36% were due to physical abuse, 37% to neglect, and 27% to sexual abuse. From 1985 to 1990, there were 255 child abuse fatalities. (Colorado Police Academy Team on Families and Children at Risk [CPAT], October, 1990)

- In 1989, of the 11,342 children and adolescents served by Colorado's public mental health system, 69% had been physically abused and 49% had been sexually abused. (CPAT, 1990)

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[1] "Substantiated case" implies a degree of certainty that a child involved is at-risk and, in many states, that some level of intervention is warranted in the child's behalf.

WITH LIMITED PREVENTION RESOURCES, SYSTEMS OVERWHELMED; OUT-OF-HOME PLACEMENTS SOAR

- From the start of 1986 to the end of 1991, there was a 49% increase in out-of-home placements, from 273,000 to 407,000.[2] In 1988, minority children constituted 46% of those placed out-of-home. (American Public Welfare Association, 1991)

- Between 25% and 50% of all child abuse fatalities occur in families that are known to the local child protection agency. (Martinez, 1986)

- Federal funding for foster care increased almost 600% between 1981 and 1991, while funds for prevention rose only 78%. (Department of Health and Human Services, 1991)

- In 1990, nearly six out of ten states experienced a decrease or no change in funding for child protection services. (NCPCA, 1991)

DRUG AND ALCOHOL ABUSE FUEL THE CHILD ABUSE CRISIS

- In a 50-state survey of child services personnel, 55% of the respondents stated that substance abuse was a primary cause for the increase in child abuse. (NCPCA, 1991)

- According to a 1990 Pennsylvania study of parents who neglected their children, 30% stated that someone in their home had a drug or alcohol problem in the last three years; 28% of the parents had been assessed as having substance abuse problems at the time of intake. (National Resource Center on Family Based Services [NRC], 1990)

- In a 1989 study of African-American children in foster care, drug abuse was listed as a contributing factor in 36% of the placements. (National Black Child Development Institute, 1989)

LONG-TERM EFFECTS OF ABUSE IMPEDE ADULT WELL-BEING

- In one study, 67% of alcoholic women reported that they had been

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[2] Out-of-home placements include family foster care, group homes, child care facilities, and emergency shelter care.

victims of sexual abuse during childhood compared with 28% of matched controls. (Miller, et al., 1987)

- In a recent Pennsylvania survey of chronically neglectful parents, 31.5% reported that they had been "beaten hard" as a child. (NRC, 1990)

PREVENTION WORKS AND SAVES MONEY

- In FY 89-90, Hawaii's statewide home visitation program reached 1,829 families at an estimated cost of $2,200 per family (may include more than one child). In contrast, the average cost of one child in protective services is $12,602 per year. There were virtually no reports of child abuse and neglect among participating families, and child abuse reports statewide declined more than 35% from 1987-1990. (Hawaii Department of Health, 1991; NCPCA, 1991)

- In Oregon, 10% of all children in families with teen parents (900) were abused. If these families had been served by the Oregon Children's Trust Fund Teen Programs, which include home visiting, parenting classes, and support groups, it is projected that only 2% would have been abused or neglected. From 1989-90, the total number of child abuse reports in the state fell 5%. (Oregon Children's Trust Fund, 1991)

- In Iowa, those counties which had crisis nurseries experienced a 13% decline in child abuse reports while reports remained constant in counties without the nurseries. Crisis nurseries provide temporary care for children when they are at-risk of abuse or neglect and are open 24-hours a day, 7-days a week. (Horn, 1991)

September 15, 1991

HEARING SUMMARY

NATIONAL CHILDREN'S DAY: HONORING OUR PROMISES TO AMERICA'S YOUTH

Washington, DC, September 30, 1991

On September 30, 1991, the Select Committee on Children, Youth, and Families held a hearing in observance of National Children's Day, entitled "National Children's Day: Honoring Our Promises to America's Youth," to explore the serious challenges confronting children and teens today and successful solutions. Youth ambassadors chosen by state governors profiled effective public and private programs in their communities and made recommendations. Other witnesses discussed strategies for positive youth development, an innovative youth voting program, and a high school response to changes in its student population.

Diana Ross, National Spokesperson, National Children's Day Foundation, testified that our nation must respond to the demands facing children imposed by discrimination, poverty, and gang violence. Ross stressed that we should assure children a safe and loving world, and suggested that special emphasis on improving the quality of education would assist in developing tomorrow's leaders.

Tammy Jo Granado, Youth Ambassador, Phoenix, AZ, described the Skills-Tenacity-Attitude-Readiness at-risk student program (STAR), a dropout prevention program in which at-risk students are counseled and exposed to social and cultural opportunities. STAR helped Granado acquire self-respect and self-confidence. She took issue with the stereotypical labeling of "at-risk" youth as non-achievers, testifying that "at-risk" actually means lack of opportunity caused by social, economic, or other reasons. Granado recommended a junior congress to advise the Congress and a mandatory class for youth on the value of pluralism and diversity.

Willie Starks, Youth Ambassador, Los Angeles, CA, praised the Young Black Scholars program (YBS), sponsored by 100 Black Men of Los Angeles, Inc., offering cultural workshops and outings, college preparation courses, and instruction in written expression, computer skills, and journalism. Starks said that YBS convinced him to study and to attend college and medical school. He outlined the difficulties facing him as an inner-city youth and credited his mother, a single parent, with helping him develop self-esteem and reject drugs and violence.

Maribel Videla, Youth Ambassador, Dunellen, NJ, described the Pupil Improvement Program (PIP), a school-based alternative classroom that provides counseling for at-risk students and advises students on academic issues, peer pressure, family problems, drugs and alcohol, and other problems. Videla stated that PIP is effective for two reasons: 1) at-risk students are identified before seventh grade; and 2) students willingly participate. She recommended that Congress support teen substance abuse prevention and treatment.

Carri Farmer, Youth Ambassador, Joplin, MO, a participant in an Independent Living Program, stated that alcoholic parents and physical and sexual abuse made her childhood difficult and resulted in foster care placement. In the program, Farmer learned valuable life skills, including money management, facts about human sexuality and responsibility, communication, and decision making. She praised the program's emphases on developing self-esteem and setting goals, which she identified as essential to breaking cycles of abuse and neglect. Farmer recommended increased support for foster care, independent living, and runaway youth programs.

Vernor Toland, Youth Ambassador, Aurora, CO, on behalf of the Jefferson County Employment and Training Program (Jeffco), recounted a troubled upbringing in which family problems led him to substance abuse and crime. While in a juvenile facility, Tolands enrolled in Jeffco, where he learned financial management, employment, and living skills. Toland stated that programs such as Jeffco are the "bridge between failure and success" for young people. He recommended, however, that intervening at an early age is essential, because intervention at age 16 is often too late.

Melissa Coleman, Youth Ambassador, Jackson, MS, discussed her transformation from an abused foster teen with low self-esteem to a confident high school senior as a result of Project Gaining Access to Independence Now (Project GAIN). Coleman asserted that Project GAIN, a foster care independent living program, improved her communication abilities, self-esteem, and daily living, employment, and school leadership skills. She performed a dramatic reading depicting the lives of youth in state custody.

Shelby Justesen, Youth Ambassador, Boise, ID, testified that the Parents and Youth Against Drug Abuse Youth to Youth program helps youth to reject drug use by empowering them to become anti-drug advocates in their schools and communities. The program, led by young people, sponsors anti-drug conferences, plays, parties, trips, and media campaigns, and trains youth to serve as peer counselors.

Justesen stated that the program has increased her self-confidence and commitment to speak out against drug use.

Nathan Ballard, Youth Ambassador, Auburn, AL, a member of the YMCA Youth in Government Youth Legislature, stated that many students, because they cannot vote, believe that they have no voice in government. Ballard argued that the Youth Legislature, by sponsoring mock legislatures throughout the country, provides a voice for youth and promotes citizenship. He testified that the program has taught him to set and to achieve goals. He identified quality education for youth as the key to ensuring a better-educated work force and an end to racial discrimination.

Karen Johnson Pittman, Vice President, Academy for Educational Development (AED); Director, Center for Youth Development and Policy Research, AED, Washington, DC, testified that children, although living in risky times, can still thrive. Pittman said that youth are often evaluated primarily in terms of problems rather than successes. She asserted that, in addition to assessing youth problems, young people's positive contributions should be recognized and encouraged and positive youth development should be promoted. Youth development would provide more effective and holistic programs and services, improve the training and responsiveness of youth workers, and engage the active participation of youth and their families.

Marilyn Evans, President and Executive Director, Kids Voting, USA, Mesa, AZ, highlighted the success of Kids Voting in Arizona, where last year 131,000 children voted at the polls on Election Day. Underscored by a voter education curriculum offered to students in grades K-12, the program encourages young people to develop opinions on political issues, question candidates, and vote. In Arizona, youth participation increased adult turnout and knowledge of the issues and yielded some conflicting results: unlike adults, youth voters elected the Democratic gubernatorial candidate, passed an education funding proposition, and instituted a Martin Luther King, Jr. holiday. Kids Voting is expanding to other states.

Mark Simon, Social Studies Teacher, Bethesda-Chevy Chase High School, Bethesda, MD, described the increasing economic, racial and ethnic diversification of the school's population. Simon stated that the school's responses to this change have enabled students to succeed in school and to develop good social relationships. Rather than track math students at various levels, the school requires that all students study algebra and geometry; students work in groups to master these subjects and, as a result, more students received A's and B's this year

in algebra than took algebra last year. Students volunteer on museum, hospital, and legislative staffs. They receive credit for school service, such as instituting a school recycling program. Simon emphasized the essential roles that teachers, community leadership and adequate funding play in developing and sustaining such programs.

HEARING SUMMARY

PREVENTING UNDERAGE DRINKING: A DIALOGUE WITH THE SURGEON GENERAL

Washington, DC, November 15, 1991

On November 15, 1992, the Select Committee on Children, Youth, and Families held the third in a series of hearings on the risky business of adolescents entitled, "Preventing Underage Drinking: A Dialogue with the Surgeon General." The hearing explored the problem of underage drinking and the serious consequences for teens. While drinking itself can have serious long-term health problems for teens, it is also usually accompanied by other high-risk behaviors such as smoking, delinquency, and early, unprotected sexual activity that can lead to unwanted pregnancy or HIV infection. Drinking can even result in death -- alcohol-related accidents such as car crashes and drowning represent the major killer of those under 18.

The Honorable Antonio Novello, M.D., M.P.H., Surgeon General of the United States, U.S. Public Health Service, Department of Health and Human Services, Washington, DC, warned the Committee that millions of teens don't know that a person can die from an alcohol overdose, and almost half think cold showers and coffee can sober up a drunk. She testified that federal regulation of alcohol labeling, advertising, and sales is fragmented, and state laws are inconsistent and unenforced. According to the Surgeon General, two thirds of teens who drink, nearly seven million, are able to walk into a store and buy their own alcohol. Alcohol advertising and promotions totalling $2 billion a year link consumption of beer and wine coolers to sports, beach parties, and sex, and some alcoholic beverage containers are indistinguishable from soda or fruit juice bottles.

The Surgeon General called upon schools, communities, parents and policymakers to eliminate the mixed messages that cripple attempts to reduce teen drinking. She specifically has requested the alcohol industry's voluntary elimination of alcohol advertising targeted to youth through lifestyle and sexual appeals, sports figures, or risky activities, as well as advertising with more blatant appeals to youth using cartoon characters and youth slang. Dr. Novello outlined numerous policy options, including sting operations at the point of purchase, prosecution of manufacturers of fake IDs, closing enforcement loopholes (largely at the state level), suspending drivers' and vendors' licenses when laws are broken, and further analysis of liability issues.

Reports on underage drinking issued by the Inspector General at the request of Dr. Novello highlighted innovative state efforts to enhance enforcement of existing state laws and suggested creative community alternatives to alcohol-centered recreation for teens.

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PREVENTING UNDERAGE DRINKING: A DIALOGUE WITH THE SURGEON GENERAL

A FACT SHEET

ALCOHOL IS THE DRUG OF CHOICE FOR ADOLESCENTS

- In 1990, one out of four youth ages 12-13 (26%) had consumed alcohol. By age 16-17, the proportion of youth reporting alcohol use doubles (49%). By senior year in high school, 90% of students have used alcohol. (National Institute on Drug Abuse [NIDA], 1991)

- In recent years, declines in alcohol use among high school seniors have not corresponded with declines in other illicit drug use. Between 1987 and 1990, the percent of high school seniors reporting marijuana use declined 18% and the percent reporting cocaine use fell 40%, while the percent of students reporting alcohol use declined only 2%. (NIDA, 1991; NIDA, 1988)

- The average age of first alcohol consumption is 12-13 years. Of those students who drink, five out of every six report having had their first drink by age 15. (Department of Health and Human Services [DHHS], 1991)

- Alcohol use varies significantly among different groups of youth. In 1990, among youth ages 12-17, 52% of white youth report having consumed alcohol, compared with 48% of Hispanic and 33% of African-American youth. (NIDA, 1991)

HEAVY DRINKING WIDESPREAD AMONG TEENS; LINKED TO OTHER DANGERS, EVEN DEATH

- Eight million junior and senior high school students (nearly 40% of this population) report weekly consumption of alcohol, including 5.4 million who have "binged" with five or more drinks in a row; 454,000 report an average weekly consumption of 15 drinks. (DHHS, 1991)

- Between 1985 and 1989, approximately 40,600 youth ages 15-24 died in alcohol-related motor vehicle accidents. Nearly seven million students report having accepted a ride with someone who has been drinking; almost half of all students who drink have been a passenger in a car that a friend drove after drinking. (Centers for Disease Control, 1991; DHHS, 1991)

- In 1988, nearly one in five youth ages 12-17 (17%) showed at least one symptom of alcohol dependency. Among students who report drinking, more than four million drink when they are upset, three million drink alone, and nearly three million students drink when they are bored or to feel high. (DHHS, 1991)

- Alcohol use has been closely associated with smoking, school failure, and early and unprotected sexual activity among adolescents. (Office of Technology Assessment [OTA], 1991)

YOUTH INUNDATED WITH ALCOHOL ADVERTISING, REPRESENT LARGE MARKET

- In 1990, $752 million dollars was spent on beer and wine advertising and $291 million dollars was spent on distilled spirits advertising. (Endicott and Brown, 1991)

- High school and junior high school students drink 35% of all wine coolers sold in the U.S. and 1.1 billion cans of beer each year. (DHHS, 1991)

- In one study, alcohol was found to be the most common drug used on television and the most frequently used beverage; alcohol was used in three-fourths (78%) of surveyed television programs, with an average of 10.65 drinking acts per hour. (Wallack, et al., 1987)

- A recent poll conducted on behalf of the alcohol industry-supported Century Council found that three-fourths of people surveyed believe that "alcohol advertising is a major contributor to underage drinking." Similarly, a 1988 survey conducted for the Bureau of Alcohol, Tobacco, and Firearms found that 80% of the population believed that "alcohol advertising influences underage youth to drink alcoholic beverages." (The Wirthlin Group, 1990; Opinion Research Corporation, 1988)

YOUTH LACK INFORMATION NEEDED TO BE SAFE CONSUMERS

- Cisco, which contains 2.5 times more alcohol than other alcoholic beverages, was identified as non-alcoholic by 36% of students recently surveyed. Similarly, among students who report drinking, 42% prefer wine coolers, yet one out of every three students does not know that all wine coolers contain alcohol. (DHHS, 1991)

- More than 2.6 million students do not know that a person can die from an alcohol overdose and nearly half (46%) of students interviewed believe that taking a cold shower, drinking coffee, or getting fresh air can help a person sober up more quickly. (DHHS, 1991)

DESPITE 21 YEAR LEGAL DRINKING AGE, ALCOHOL READILY AVAILABLE TO TEENS

- Almost two-thirds of students who drink buy their own alcohol; 7 million students report being able to walk into a store to purchase alcohol. (DHHS, 1991)

- During a recent Insurance Institute for Highway Safety study, minors successfully bought alcohol in 44-80% of New York stores and in 97% of Washington, D.C. stores.
(DHHS, 1991)

STATE AND FEDERAL RESPONSE INADEQUATE; REGULATION INCONSISTENT

- The National Institute on Alcohol Abuse and Alcoholism, which is the primary federal agency responsible for research on alcohol abuse, devoted only $6.1 million or 5% of its budget to adolescents. (OTA, 1991)

- A Fall 1989 survey of state substance abuse directors showed at least 1.6 million adolescents in the U.S. need treatment for alcohol and other drug abuse, but only 123,500 are receiving treatment. (National Association of State Alcohol and Drug Abuse Directors, 1990)

- Although *sale* of alcoholic beverages to minors is illegal in all 50 states and the District of Columbia), minors can legally *sell* alcohol without supervision in 44 states, *possess* alcohol in 35 states,

consume alcohol in 21 states, and *purchase* alcohol in 6 states. (DHHS, 1991)

MODELS OF EFFECTIVE CAMPAIGNS EXIST

- Participants in a comprehensive alcohol and other drug abuse prevention program for students in grades 6-7 were at least 50% less likely than students in a control group to use alcohol, cigarettes, or marijuana one year after the study. Parents of participating students were more likely to report reduced alcohol use and increased physical activity. The program supplemented peer pressure resistance skills training with parental involvement, community organization, and promotion of local health policy change. (Pentz, et al., 1989)

- Current federal excise tax rates vary considerably by alcohol products. The tax rate per gallon of beer is $0.58, compared with $1.07 for wine and $13.50 for liquor. Studies have shown that raising the tax of a six-pack of beer by 21.5 cents would significantly reduce teenage drinking and highway mortality among youth ages 18-20 by 27%. (Center for Science in the Public Interest [CSPI], 1991; CSPI, 1989)

- A 1989 study showed that countries with bans on spirits advertising have about 10% lower alcohol consumption and motor vehicle fatality rates than countries with no bans, and those that ban advertising beer and wine have about 23% lower alcohol consumption and motor vehicle fatality rates. (Saffer, 1989)

November 15, 1991

HEARING SUMMARY

AUTOMOTIVE SAFETY: ARE WE DOING ENOUGH TO PROTECT AMERICA'S FAMILIES

Washington, DC, December 4, 1991

The fact that motor vehicle related injuries are the number one cause of death of children and adolescents in all age groups led the Select Committee on Children, Youth, and Families to hold the first hearing supported by its new investigative unit. The hearing focused on motor vehicle safety, examining whether or not the National Highway Traffic Safety Administration (NHTSA) and the motor vehicle industry are doing enough to reduce the number of deaths and injuries on America's roadways.

The Committee looked in particular at the failure of NHTSA to act on two safety issues. The first involved the failure of NHTSA and the automotive industry to inform the public of safety problems inherent in "window-shade" and "passive" seatbelt systems. The second issue involved a proposed rule, unresolved at NHTSA for approximately a quarter of a century, to safeguard against truck underride, one of the most catastrophic accidents occurring on U.S. roadways.

The Committee heard testimony specifically addressing these two issues as well as the history of manual and passive restraint systems, an overview of the continued effects on families of these safety issues and the economic costs of automotive deaths and injuries.

Witnesses appearing before the Committee were:

Joan Claybrook, President Public Citizen, Washington, DC

Byron Bloch, Consultant, Auto Safety Design, Potomac, MD

Ben Kelly, President, Institute for Injury Reduction, Upper Marlboro, MD

Brian O'Neill, President, Insurance Institute for Highway Safety, Arlington, VA

Witnesses from both the Administration and the trucking industry were scheduled to testify, but did not appear for the hearing.

LIST OF WITNESSES

AND THOSE WHO SUBMITTED TESTIMONY

FOR THE RECORD

LIST OF WITNESSES AND THOSE WHO SUBMITTED TESTIMONY FOR THE RECORD

(testified before the Select Committee on Children, Youth, and Families)*

RECLAIMING THE TAX CODE FOR AMERICAN FAMILIES

* Bauer, Gary L., President Family Research Council, Washington, DC
* Brennan, Heidi, Co-executive Director, Mothers At Home, Vienna, VA
* Campbell, Nancy Duff, Managing Attorney, National Women's Law Center, Washington, DC
Coats, The Hon. Dan, U.S. Senator from the State of Virginia
Forman, Jonathan Barry, Visiting Associate Professor, University of Oklahoma, College of Law, Norman, OK
* Lake, Celinda, Vice President, Greenberg-Lake, Washington, DC
* Shapiro, Robert J., Ph.D., Vice President, Progressive Policy Institute, Washington, DC
* Smeeding, Timothy M. Ph.D., Professor of Economics and Public Administration, Metropolitan Studies Program, the Maxwell School, Syracuse University; and Project Director, Luxembourg, Income Study , Syracuse, NY
* Steuerle, C. Eugene, Ph.D., Senior Fellow, the Urban Institute, Washington, DC

GENERATING INNOVATIVE STRATEGIES FOR HEALTH INFANTS AND CHILDREN

* Bliley, Thomas J., Jr., Representative in Congress from the State of Virginia
* Bradley, Hon. Bill, U.S. Senator in Congress from the State of New Jersey
Dandoy, Suzanne, M.D., M.P.H., President, Association of State and Territorial Health Officials, McLean, VA
Degnon, George, CAE, Executive Vice President, Association of State and Territorial Health Officials, McLean, VA
* Gomez, Maria, S., Executive Director, Mary's Center for Maternal and Child Care, Inc., Washington, DC
* Harmon, Robert G., M.D., Administrator, Health Resources and Services Administration, U.S. Department of Health and Human Services, Rockville, MD
* Johnson, Kay, Senior Health Policy Advisor, March of Dimes Birth

Defects Foundation, Washington, DC

* Jones, Judith, Associate Clinical Professor and Director, National Center for Children in Poverty, Columbia University School of Public Health, New York, NY

CLOSE TO HOME: COMMUNITY BASED HEALTH SERVICES FOR CHILDREN

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* Jordan, Dixie, Parent and Advocate, Parent Advocacy Coalition for Educational Rights (PACER Center) Minneapolis, MN

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* Wilder, Hon. L. Douglas, Governor, Commonwealth of Virginia, accompanied by Charles Kehoe, Director, Virginia Department of Youth and Family Services, Richmond, VA

ON THE FRONT LINES: POLICE STRESS AND FAMILY WELL-BEING

* Anderson, Beverly J., M.A., C.A.C., Clinical Director/Program Administrator, Metropolitan Police Employee Assistance Program, Washington, DC

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- Reese, James T., Ph.D., Supervisory Special Agent, Assistant Unit Chief, Behavioral Science Services Unit, Training Division, Federal Bureau of Investigation, Quantico, VA
- Riggs, Cathy, former police officer, Santa Rosa Police Department and wife of Representative Frank Riggs (former police officer), Santa Rosa, CA

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- Scrivner, Ellen, Ph.D., Director, Psychological Services Division, Prince George's County Police Department, Upper Marlboro, MD; and President Elect, Division of Psychologists in Public Service, American Psychological Association, Washington, DC
- Sommers, Gary W., Sergeant, Training Services, Prince George's County Police Department Landover, MD, accompanied by Kay Sommers, Laurel, MD

Stover, William K., Police Chief, Arlington County Police Department, Arlington, VA

- Zavaras, Aristedes W., Chief, Denver Police Department, Denver, CO

BABIES AND BRIEFCASES: CREATING A FAMILY-FRIENDLY WORKPLACE FOR FATHERS

Association of Part-Time Professionals, Falls Church, VA

- Hayes, Lynn O'Rourke, Author, Parents," Chevy Chase, MD
- King, Beverly, Director of Human Resources, City of Los Angeles, Department of Water and Power, Los Angeles, CA
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- Mattox, William R., Jr., Director of Policy Analysis, Family Research Council, Washington, DC
- Miedzian, Myriam, Ph.D., author, New York, NY
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THE RISKY BUSINESS OF ADOLESCENCE: HOW TO HELP TEENS STAY SAFE

(Part I)

Ambach, Gordon M., Executive Director, Council of Chief State School Officers (CCSSO), Washington, DC
Caperton, Hon. Gaston, Governor, State of West Virginia
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* Sullivan, Kathleen M., Director, Project Respect, Golf, IL
Vincent, Murray L., Ed.D., Professor, School of Public Health, University of South Carolina, Bambera, SC
* Wodraska, Dorothy, Assistant Director, Project I-STAR, Inc., Indianapolis, IN
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(Part II)

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Lehman, Mark Paul, Human Rights Campaign Fund, Washington, DC

* Lyons, John F., Ph.D., Associate Professor of Psychiatry, Psychology, and Medicine, Northwestern University Medical School, Chicago, IL

Marquis, Damon K., Director of Health Education, National Commission on Correctional Health Care, Chicago, IL

* Mayden, Bronwyn, Executive Director, Governor's Council on Adolescent Pregnancy; accompanied by Cathy Cardall, parent of a member of the Health Opportunities for Teens Advisory Board, Baltimore, MD

* Presentation of "Secrets" by D'Monroe, April Jones, Keith Kaplin, Andy Pang, and Christy Winters, accompanied by Joseph A. Klosson, Kaiser Permanente, Washington, DC

* Ray, Eleshia, Peer Educator and Youth Coordinator, PEER Program, Terrific Inc., Washington, DC

* Selverstone, Robert, Ph.D., President, Board of Directors, SIECUS (Sex Information and Education Council of the United States, Westport, CT

Shalwitz, Janet, M.D., Director, Special Programs for Youtth, San Francisco, CA

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* Walker, Gil, Commissioner, Chicago Housing Authority, The Midnight Basketball League, accompanied by Burtell Selph, Player, Chicago, IL

Wattleton, Faye, President, Planned Parenthood of America, Inc., Washington, DC

Wilcox, Brian L., Ph.D., Director, Legislative Affairs and Policy Studies, American Psychological Association, Washington, DC

Wilson, Mercedes Arzu, President, Family of the Americas Foundation, Inc., Mandeville, LA

TURN IT DOWN: THE EFFECTS OF NOISE ON CHILDREN AND YOUTH

American Academy of Otolaryngology--Head and Neck Surgery, Inc., Alexandria, VA

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Doyle, John, Secretary and Member, Board of Directors, Hearing Education and Awareness for Rockers, San Francisco, CA

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Lockwood, Martha J., CAE, APR, Executive Vice President, Car Audio Specialists Association/Vehicle Security Association, Washington, DC

* Snow, James B., Jr., M.D., Director, National Institute on Deafness and Other Communication Disorders, National Institutes of Health, Bethesda, MD

Spahr, Frederick T., Ph.D., Executive Director, American Speech-Language-Hearing Association

* Stone, Howard E. "Rocky," CEO and Executive Director, Self Help For Hard Of Hearing People, Inc. (SHHH), Bethesda, MD

CHILD ABUSE PREVENTION AND TREATMENT IN THE 1990's: KEEPING OLD PROMISES AND MEETING NEW DEMANDS

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Murphy, Steven J., Director, Hillsdale County (Michigan) Department of Social Services; and President, National Association of Public Child Welfare Administrators (an affiliate of American Public Welfare Association), Washington, DC

New Beginnings, Integrated Services for Children and Families, San Diego, CA

Rewerts, Milan, Interim Director, Colorado State University Cooperative Extension Child Abuse Prevention Programs, Fort Collins, CO

NATIONAL CHILDREN'S DAY: HONORING OUR PROMISES TO AMERICAN YOUTH

* Ballard, Nathan A., Youth Ambassador of Alabama, Auburn, AL
* Coleman, Melissa, Youth Ambassador of Mississippi, Jackson, MS

Danuser, Carrie Elizabeth, Youth Ambassador of North Dakota, Marion, ND

Dowling, Michael J., Senior, Wil Lou Gray Opportunity School, West Columbia, SC

Elder, Jennifer E., Youth Ambassador of Maryland, La Plata, MD

* Evans, Marilyn, President and Executive Director, Kids Voting, USA, Mesa, AZ
* Farmer, Carri, Youth Ambassador of Missouri, Joplin, MO
* Granado, Tammy Jo, Youth Ambassador of Arizona, Phoenix, AZ
* Justesen, Shelby, Youth Ambassador of Idaho, Boise, ID

Kalley, Kristina, Youth Ambassador of Florida, Madison, FL

Levy, David L., Esq., President, National Council for Children's Rights, Washington, DC

Paris, Chuck, President, CEO/Founder, Positive I.D., Inc., Orlando, FL

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Romeo, Lisa, Member, Nebraska Foster Care Youth Advisory Board, Lincoln, NE

* Ross, Diana, National Spokesperson, National Children's Day Foundation
* Simon, Mark, Social Studies Teacher, Bethesda-Chevy Chase High School, Bethesda, MD
* Starks, Willie, Youth Ambassador of California, Los Angeles, CA
* Thrasher, Anthony W., Youth Ambassador of Illinois, Springfield, IL
* Toland, Vernor L., Youth Ambassador of Colorado, Aurora, CO
* Videla, Maribel, Youth Ambassador of New Jersey, Dunellen, NJ

PREVENTING UNDERAGE DRINKING: A DIALOGUE WITH THE SURGEON GENERAL

Calfee, John E., Associate Professor of Marketing, School of Management, Boston University, Boston, MA

Kavanuagh, Michael F., Sheriff, County of Roanoke, Salem, VA

* Novello, Antonia C., M.D., M.P.H., Surgeon General, U.S. Public Health Service, Department of Health and Human Services, Washington, DC

AUTOMOTIVE SAFETY: ARE WE DOING ENOUGH TO PROTECT AMERICA'S FAMILIES?

* Bloch, Byron, Auto Safety Design, Potomac, MD
* Claybrook, Joan, President, Public Citizen, Washington, DC
* Kelley, Ben, President, Institute for Injury Reduction, Ulppaer Marlboro, MD
* O'Neill, Brian, President, Insurance Institute for Highway Safety, Arlington, VA

HIGHLIGHTS OF LEGISLATION

AFFECTING CHILDREN, YOUTH, AND FAMILIES

PART I

HIGHLIGHTS OF LEGISLATION AFFECTING CHILDREN, YOUTH, AND FAMILIES ENACTED INTO LAW DURING FIRST SESSION OF THE 102nd CONGRESS

EMPLOYMENT AND CIVIL RIGHTS

- **The Civil Rights Act of 1991 (H.R. 1, S. 1745; P.L. 102-166)** overturns five key 1989 Supreme Court decisions that made it more difficult for women and minorities to obtain redress from the courts for employment discrimination. The law shifts the burden to the employer to prove that an employment policy or practice that adversely affects women or minorities is a business necessity, and, for the first time, allows compensatory and punitive damages to victims of job discrimination based on sex, religion, or disability. It establishes a commission to examine the "glass ceiling" effect that limits advancement opportunities for women and minorities.

- **The Federal Supplemental Compensation Act of 1991 (H.R. 3575, P.L. 102-164; and H.R. 1724, P.L. 102-182)** extend unemployment compensation benefits to workers who have exhausted their regular 26 weeks of benefits (the second bill, enacted shortly after the first, provides more generous benefits than the first). The final legislation provides either 13 or 20 weeks of additional benefits, depending on the state's insured unemployment rate. The new law is financed by speeding up tax collections on certain high-income taxpayers, garnishing wages of those who default on student loans, and extending the current rate on the unemployment tax on employers for one year.

- **The Nontraditional Employment for Women Act (S.367, P.L. 102-235)** amends the Job Training Partnership Act to require goals for training and placing women in jobs traditionally dominated by men and to disseminate information about successful strategies for nontraditional employment and training opportunities. The bill also sets aside $1.5 million for six states to develop demonstration projects to develop and expand nontraditional training programs.

- **Rehabilitation Act Amendments of 1991 (H.R. 2127, P.L. 102-52)** extends Rehabilitation Act programs (which provide vocational rehabilitation and independent living programs for individuals with disabilities) through FY 1992.

CHILDREN, YOUTH, AND FAMILIES IN CRISIS AND FAMILY SUPPORT

- **Protection and Advocacy for Mentally Ill Individuals Amendments Act of 1991 (S. 1475, P.L. 102-173)** extends through FY 1995 the authorization for federal grants to states to operate protection and advocacy systems for mentally ill individuals. These systems are designed to protect the legal rights of individuals with mental illness and to investigate incidents of neglect and abuse.

- **Abandoned Infants Assistance Act Amendments of 1991 (H.R. 2722, S. 1532; P.L. 102-236)** extend through FY 1995 the authorization of appropriations for federal demonstration grants to provide foster or other residential care for infants and young children who have been abandoned in hospitals (most of whom are born infected with the HIV virus or affected by drugs). The existing demonstration programs are supplemented by new model comprehensive service centers to prevent abandonment and to care for infants and young children who have been abandoned by providing health, education, and social services at one site.

- **Drug Abuse Prevention for Youth Gangs and Runaway and Homeless Youth (H.R. 3259, P.L. 102-132)** amends the Anti-Drug Abuse Act of 1988 to extend through FY 1994 the authorization of appropriations for drug abuse education and prevention programs for youth gangs and runaway and homeless youth.

- **Extension of Temporary Protected Status for Salvadoran Families (H.R. 2332, P.L. 102-65)** extended by four months, until October 31, 1991, the application deadline for special temporary protected status for Salvadoran families.

- **National Defense Authorization Act for Fiscal Years 1992 and 1993 (H.R. 2100, P.L. 102-190)** permanently extends the **Military Adoption Reimbursement Program** to members of the armed forces for adoption expenses.

CHILD, ADOLESCENT, AND FAMILY HEALTH AND SAFETY

- **Health Information, Health Promotion, and Vaccine Injury Compensation Amendments of 1991 (H.R. 3402, P.L. 102-168)** extend for five years the authorization of federal programs concerning health information and health promotion, including preventive medicine, health education, and health information for consumers.

The law also establishes the Office of Disease Prevention and Health Promotion within the Office of the Assistant Secretary of Health and makes technical amendments to the National Childhood Vaccine Injury Compensation program.

- **Medicaid Moratorium Amendments of 1991 (H.R. 3595, P.L. 102-234)** impose restrictions on the types of state revenues for which federal matching payments are available under the Medicaid program. Effective October 1, 1992, federal matching payments would no longer be available for revenues from "voluntary donations" to states from health care providers and would only be available for revenues from provider taxes that are "broad-based" (taxes uniformly applied to all health care providers in a class, such as all hospitals or all nursing homes). In addition, a cap of 25% of a state's Medicaid expenditures is imposed on the amount of revenues from broad-based provider taxes that a state can use to fund either share of Medicaid. The act further provides that states can spend no more than 12% of their total Medicaid outlays on bonus payments for "disproportionate share" hospitals (i.e., hospitals with a disproportionate share of low-income patients).

- **Labor, Health and Human Services, Education and Related Agencies Appropriations for FY 1992 (H.R. 3839, P.L. 102-170)** earmarks $2 million to create an Office of Adolescent Health in the Health Resources and Services Administration. The Office was directed to establish a blue-ribbon advisory committee for oversight and to, "...Insure that projects funded combine education and health programs, for example, nursing school-administered clinics on school grounds."

- **Food, Agriculture, Conservation, and Trade Act Amendments of 1991 (H.R. 3029, P.L. 102-237)** include provisions authorizing the establishment of a rural health leadership development program to provide grants to assist rural areas in developing health care services and facilities.

- **Treasury, Postal Service, General Government Appropriations Act for FY 1992 (H.R. 2622, P.L. 102-141)** includes a provision requiring states to adopt the guidelines issued by the federal Centers for Disease Control that are designed to prevent the transmission of the HIV virus and the hepatitis B virus from health professionals to their patients, or equivalent guidelines.

- **Agent Orange Act of 1991 (H.R. 556, P.L. 102-4)** enacts into law permanent disability benefits for Vietnam veterans who suffer certain

conditions due to exposure to Agent Orange, and sets out procedures to determine whether other conditions are related to exposure to Agent Orange, so that Vietnam veterans suffering from these conditions could be eligible for VA disability benefits.

- **Intermodal Surface Transportation Infrastructure Efficiency Act of 1991 (H.R. 2950, P.L. 102-240)** authorizes appropriations from the Highway Trust Fund to develop a national intermodal surface transportation system, to construct and repair highways, bicycle paths, and pedestrian walkways, and to establish highway and bicycle safety programs; requires airbags in all new passenger cars by September 1997 and in all light trucks a year later; and requires states to enact mandatory seat belt and motorcycle helmet use laws or lose a portion of their federal highway apportionment.

EDUCATION

- **The National Literacy Act (H.R. 751, P.L. 102-73)** authorizes various federal literacy programs and establishes the National Institute for Literacy and the National Institute Board, and authorizes the Secretary of Education to develop a network of national, state, and regional resource centers to help reduce the high rate of illiteracy. Authorizes funding for grants for exemplary demonstration partnerships for workplace literacy. Renames the Even Start program the Even Start Family Literacy Program and expands eligibility for funding to community-based organizations and other nonprofit organizations applying in collaboration with local educational agencies.

- **School Dropout Demonstration Assistance Act Amendments (H.R. 2313, P.L. 102-103)** extend several education programs through FY 1993 that test and evaluate promising strategies for preventing students from dropping out of school. The amendments also extend the Excellence in Mathematics, Science and Engineering Act of 1990, which provides undergraduate science scholarships, and amends the Star Schools Program, which provides demonstration grants for telecommunications partnerships to improve mathematics, science, and foreign language education.

- **The Individuals with Disabilities Education Act Amendments of 1991 (H.R. 3053, S. 1106; P.L. 102-119)** extend Part H, the Infants and Toddlers Program, which authorizes funding to states to develop statewide systems to serve children with disabilities under the age of three and their families. The legislation also modifies the Preschool

Grant program to allow Part B funds of the State Grant Program to be used for children who will reach their third birthday during the school year, whether or not they were already receiving services under Part H, and increases the funding ceiling per preschool child from $1,000 to $1,500. In addition, it allows states to include under their definitions of children with disabilities those children with physical, cognitive, communication, social or emotional adaptive disorders. Establishes a federal interagency coordinating council for early intervention services.

- **The Education Council Act of 1991 (S. 64, P.L. 102-62)** establishes a national commission to study the benefits of a longer school year, and creates a national council to study the desirability and feasibility of national standards and testing in education.

HOUSING

- **Resolution Trust Corporation Refinancing Act of 1991 (H.R. 3435, P.L. 102-233)** includes provisions to expand and improve the Resolution Trust Corporation's (RTC) affordable housing program by permanently expanding the types of properties that may be sold through the program; authorizing RTC to provide certain credit enhancements in connection with the issuance of local tax-exempt housing bonds; eliminating certain minimum sales price requirements and extending the exclusive period during which only eligible parties may purchase certain properties; requiring families to live in homes purchased under the program for at least one year, and directing the RTC to recapture most of any resale profits if the property is resold within that year; and increasing, under certain circumstances, the percentage of units in multifamily properties that must be reserved for low-income families.

- **Resolution Trust Corporation Funding Act (S. 419, P.L. 102-18)** includes provisions to expand, for FY 1991 only, the RTC's affordable housing program to include within the program single-family properties that are held by thrifts under RTC conservatorship.

VETOED LEGISLATION

- **Emergency Unemployment Compensation Act (H.R. 3040, S. 1722)** provided up to 20 weeks of extended unemployment benefits to those who exhaust their regular state unemployment benefits, depending on the state unemployment rate, through July, 1992. The

measure specified that enactment of the bill would automatically constitute a declaration of an "emergency" for budget purposes, thereby eliminating the need for a separate presidential declaration of a budget emergency. Vetoed by the President. Senate failed to override the veto. The President subsequently signed legislation (P.L. 102-164, P.L. 102-182) providing extended benefits without the emergency designation.

- **Labor, Health and Human Services, and Education Appropriations Act for FY 1992 (H.R. 2707)** banned the use of funds to implement the Administration's "gag-rule" regulations that prohibit federally funded family planning clinics from providing any information about abortion. Vetoed by the President; House failed to override the veto. The President subsequently signed an FY 1992 Labor, HHS, Education Appropriations bill (P.L. 102-170) that was identical to the vetoed bill, but without the ban on use of funds to implement the "gag-rule."

- **District of Columbia Appropriations Act (H.R. 2699)** would have permitted Washington, D.C. to use its own locally raised tax revenues to pay for abortions. The bill banned the use of federal funds to pay for abortions unless the life of the woman would be endangered if the fetus were carried to term. Vetoed by the President. No attempt was made to override the veto. The President signed a subsequent bill (H.R. 3291) that was virtually identical to the vetoed bill, except that it prohibited the use of any funds -- local or federal -- to pay for abortions, unless the life of the woman would be endangered if the fetus was carried to term.

December 19, 1991

PART II

HIGHLIGHTS OF LEGISLATION PASSED BY HOUSE AND/OR SENATE IN THE FIRST SESSION OF THE 102nd CONGRESS

EARLY INTERVENTION

- **Dire Emergency Supplemental Appropriations for FY 1992 (H.R. 3543, H.J. Res. 157)** included a provision appropriating supplemental emergency funds for Head Start, the Special Supplemental Food Program for Women, Infants, and Children (WIC), and the Childhood Immunization Program. Passed the House and Senate, but dropped by conference committee.

EMPLOYMENT/JOB TRAINING

- **The Family and Medical Leave Act (H.R.2, S.5)** requires employers with 50 or more employees, including the federal government and the House and Senate, to provide up to 12 weeks of unpaid, job-protected leave each year following the birth or adoption of a child, or for a serious health condition of the employee, his or her spouse, children or parents. The measure requires the employer to continue health benefits while the employee is on leave. Passed the House and Senate.

- **Job Training Reform Amendments (H.R. 3033)** amend the Job Training Partnership Act to improve the delivery of services to hard-to-serve youth and adults. The bill mandates that, in addition to requirements that job training participants be economically disadvantaged, at least 60% of those served in the adult and youth programs in a local service delivery area must also have limited work histories and substantial barriers to employment. Passed the House.

CHILDREN, YOUTH, AND FAMILIES IN CRISIS

- **Child Abuse Program, Adoption Opportunities, and Family Violence Prevention Extension Act of 1991 (H.R. 2720, S. 838)** extends for one year the authorizations of appropriations for programs under the Child Abuse Prevention and Treatment Act, the Family Violence Prevention and Services Act, and the Adoption Opportunities Act. Passed the House. The Senate bill extends these programs through

FY 1994 and includes reauthorization of the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act. Passed the Senate.

- **Temporary Child Care for Children With Disabilities and Crisis Nurseries Act Amendments of 1991 (H.R. 3034)** amends the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act of 1986 to extend the authorization of appropriations through FY 1994. Passed the House.

- **Violent Crime Control and Law Enforcement Act of 1991 (H.R. 3371)** includes the following provisions related to child abuse: a national system of criminal background checks for people who work with children and imposition of the death penalty for child abuse murders. The bill also makes international parental kidnapping a federal felony and provides training grants for state and local officials that deal with this problem. Conference agreement passed the House.

- **Foreign Operations, Export Financing, and Related Programs Appropriations for FY 1992 (H.R. 2621)** includes an earmark of $4 million in FY 1992 for humanitarian assistance for Romanian children. Of this amount $1.5 million is for AIDS and other health and child survival activities, $1 million is for family reunification, foster care and adoption, and $1.5 million is for family planning. Passed the House.

- **Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1991 (S. 1306)** establishes grants for home-based services for at-risk families to promote healthy development of children in such families. The legislation incorporates the "Children's and Communities Mental Health Systems Improvement Act," which authorizes grants to states for five years to develop coordinated, community-based services for children with serious emotional disturbances. Passed the Senate.

ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT

- **Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1991 (S. 1306)** establishes grants to provide comprehensive services for children of substance abusers and their families, and training grants for professionals who work with children of substance abusers and their families. The Act authorizes $75 million for each of three years for the Office of Substance Abuse

Prevention (OSAP) to provide a continuum of services for substance-abusing women, and earmarked $10 million for residential treatment slots in facilities that would also house the child. Reporting requirements for the 10% set-aside for women were strengthened. In addition, the Act authorizes $75 million for each of three years for high-risk youth programs through OSAP. Passed the Senate. (See CHILDREN, YOUTH, AND FAMILIES IN CRISIS and CRIME PREVENTION AND FAMILY SUPPORT)

- **The Drug Free Schools and Communities Act Amendments (H.R. 3057)** mandates technical assistance to programs tailored to minorities and high-risk youth, and evaluations of programs. Passed the House.

CHILD, ADOLESCENT, AND FAMILY HEALTH

- **The National Institutes of Health Revitalization Amendments of 1991 (H.R. 2507)** include $3 million per year from the budget of the National Institute for Child Health and Human Development to conduct a longitudinal study of adolescent health with a focus on mental health, access to health services including preventive services, and health promoting or threatening behaviors in which adolescents engage. In addition, the legislation includes several provisions to increase research on women's health concerns: creates an Office of Research on Women's Health at the National Institutes of Health (NIH); requires that women be included as research subjects in NIH-funded clinical trials, unless it would be inappropriate to the purpose of the research; and earmarks additional funding for breast cancer and ovarian cancer research. Passed the House.

- **The Title X Pregnancy Counseling Act of 1991 (S. 323)** overturns the "gag rule" by requiring federally funded family planning clinics to counsel women with unintended pregnancies about all their options for dealing with the pregnancy, including abortion. It also requires the Department of Health and Human Services to collect data about pregnancy. Passed the Senate.

- **Health Professions Education Amendments of 1991 (H.R. 3508)** extend for three years the authorization of a number of health professions and nursing education programs, many of which support training in primary care, such as family medicine, increasing the supply of health professionals in underserved areas, and increasing the opportunities of disadvantaged students to become health professionals. Reforms the Health Education Assistance Loan

Program and extends the Area Health Education Centers, Border Health Centers, and the Health Education and Training Center programs. Passed the House and Senate. Conferees appointed.

- **Preventive Health Amendments of 1991 (H.R.3635, S.1944)** revises and extends through FY 1996 state programs including fluoridation, rodent control, hypertension control, health education and risk reduction, and general preventive health service, and grants to states to establish plans for meeting the year 2000 health goals established by the Department of Health and Human Services. The House measure establishes a non-profit foundation for the Centers for Disease Control to work with private and public sectors on disease control and public health issues. The Senate measure establishes new programs related to injury prevention, lead poisoning, infertility and sexually transmitted diseases and expands the childhood immunization program. S.1944 also establishes demonstration programs for women's and minority health and Comprehensive Perinatal Care and Early Childhood Health programs in medically undeserved areas. Passed House and Senate. Conferees appointed.

ENVIRONMENTAL SAFETY

- **Indoor Air Quality Act of 1991 (S. 455)** requires the Environmental Protection Agency to expand and strengthen indoor air research and establish a technology demonstration program, conduct an assessment of indoor air quality in schools and buildings that house child care facilities, develop and publish health advisories on indoor air contaminants, and make grants to States to develop and implement air pollution standards. The measure also expands the authority of the National Institute of Occupational Safety and Health to conduct assessments of buildings that are declared to be unhealthy. Passed the Senate.

DISABLED CHILDREN AND THEIR FAMILIES

- **The Silvio O. Conte Disabilities Prevention Act (H.R. 3401)** authorizes for three years the Centers for Disease Control to award grants for programs for the prevention of disabilities and the prevention of secondary conditions resulting from disabilities. The types of programs to be awarded grants include service programs, studies, public education, and education and training of health care workers. Passed the House.

- **Temporary Child Care for Children With Disabilities and Crisis Nurseries Act Amendments of 1991 (H.R. 3034, S. 838)** (See CHILDREN AND FAMILIES IN CRISIS)

CRIME PREVENTION AND FAMILY SUPPORT

- **Violent Crime Control and Law Enforcement Act of 1991 (H.R. 3371)** includes the Law Enforcement Family Support Act, which authorizes grants to state and local law enforcement agencies to provide family support services and stress-reduction training to police and their families. In addition, the Act includes a provision to increase federal penalties for employing children to distribute drugs, and sets additional penalties for crimes committed as a member of, or on behalf of, a criminal street gang. Legislation also includes authorization of funding for grants to local agencies for Midnight Basketball Leagues, sports-linked programs of educational and jobs-skills training for high-risk youth, and for technical assistance and evaluation. Conference agreement passed the House. (See CHILDREN, YOUTH, AND FAMILIES IN CRISIS)

- **Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1991 (S. 1306)** establishes grants for home-based services for at-risk families to promote healthy development of children in such families. Passed the Senate. (See CHILDREN, YOUTH, AND FAMILIES IN CRISIS and ALCOHOL AND DRUG ABUSE)

- **The Family and Medical Leave Act (H.R. 2, S. 5)** (See EMPLOYMENT/JOB TRAINING)

NUTRITION

- **Farmers' Market Nutrition Act of 1991 (S. 1742)** authorizes grants to states to provide resources to persons who are nutritionally at risk in the form of food from farmers' markets and to expand the awareness and use of farmers' markets. Coupons are to be distributed to persons at nutritional risk and can be exchanged for fresh nutritious unprepared foods at farmers' markets. Passed the Senate.

December 19, 1991

MINORITY FACT SHEETS

GENERATING INNOVATIVE STRATEGIES FOR HEALTHY INFANTS AND CHILDREN

MINORITY FACT SHEET

April 23, 1991

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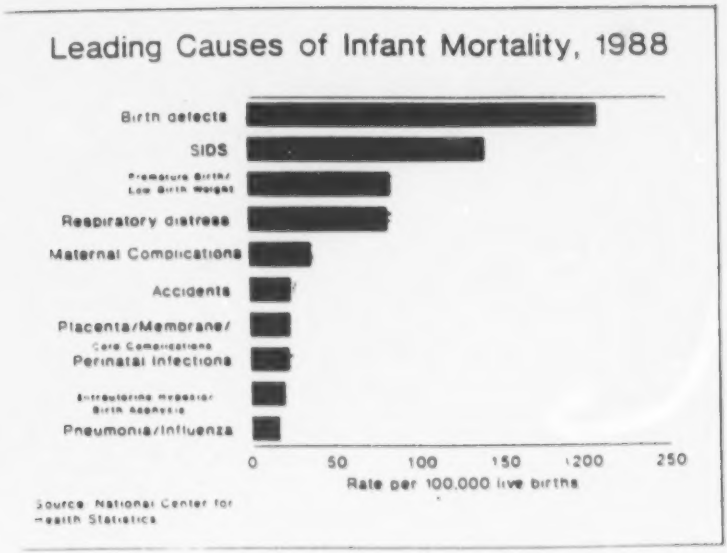
I. THE LIMITS OF TECHNOLOGY IN ADDRESSING INFANT MORTALITY

- The 1990 provisional infant mortality rate is 9.1 infant deaths per 1,000 live births, a drop below the provisional estimate of 9.7 percent for 1989. **The 1990 rate of 9.1 represents the biggest single-year decline in a decade.** (Statement by Secretary of Health and Human Services Dr. Louis Sullivan, April 8, 1991, p.2)

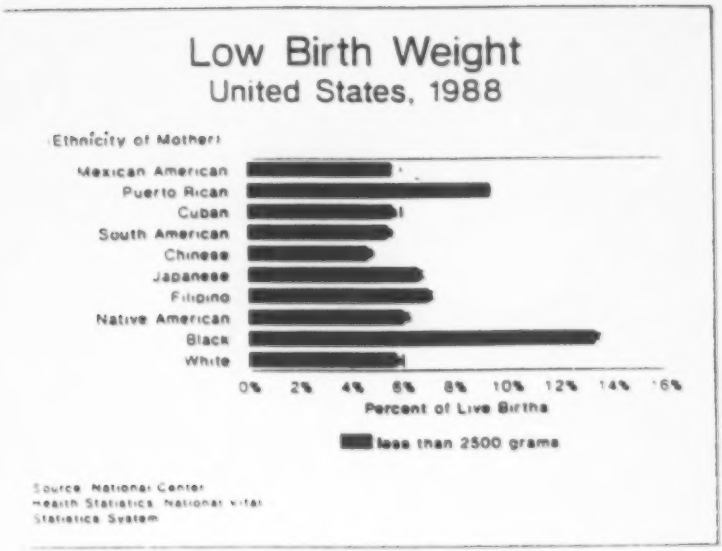
- The decline of infant mortality rates in the 1970s has been **attributed largely to the invention of medical technology** for the care of premature and other critically ill newborns. In the 1980s, this decline has slowed tremendously -- partly because of a lack of progress in primary prevention of conditions which lead to infant death. (Center for Disease Control, Morbidity and Mortality Weekly Report, September 22, 1989, Vol. 38, No. 37, page 635. Public Health Service, U.S. Department of Health and Human Services.)

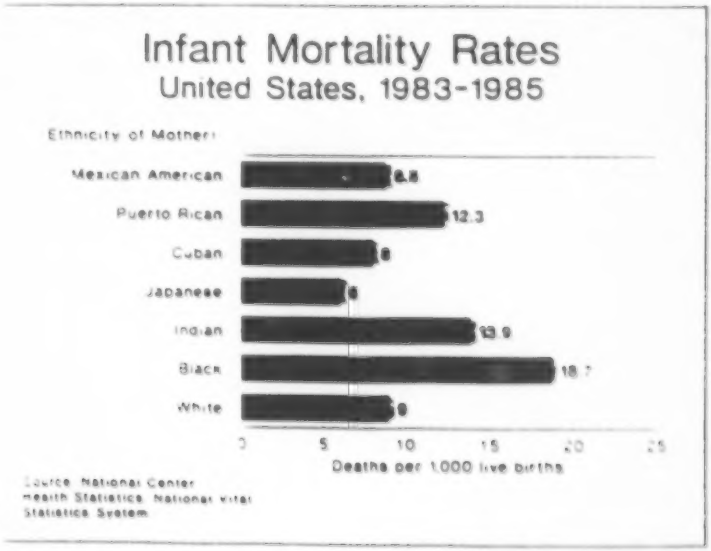
- In the past 25 years, only a small proportion of the dramatic reduction in infant mortality has been due to a reduction in the prevalence of low birth weight. The approximately twofold higher infant mortality rate of blacks as compared with whites is due primarily to their different rates of delivering preterm low-birth-weight infants, particularly those weighing less than 1500 grams. (Editorial, The New England Journal of Medicine, Vol. 317, No. 12, p. 763)



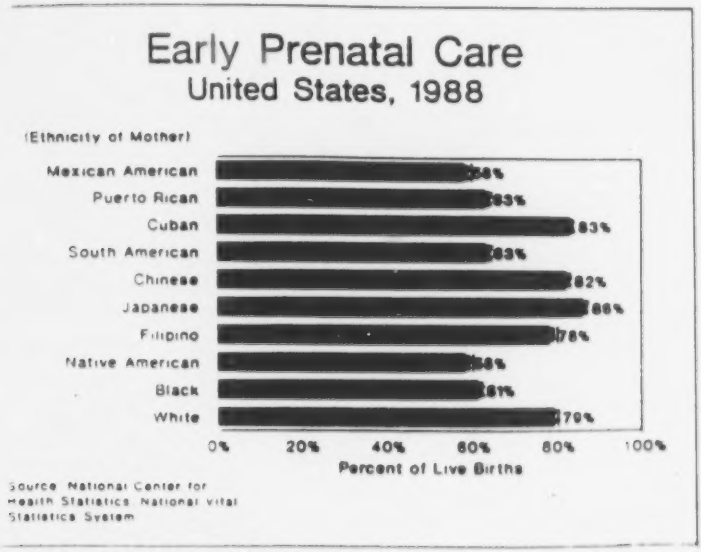
- The leading causes of infant mortality in 1988 were birth defects, sudden infant death syndrome (SIDS), low birth weight, and respiratory distress. [See chart above] These top causes can in many cases be linked to aberrant behavior during pregnancy. For example, a number of the risk factors related to SIDS are maternal smoking and drug use, teenage birth and infections late in pregnancy. (Healthy People 2000, Maternal and Infant Health, p. 369)

- The low birth weight distributions among various ethnic groups correlates with the infant mortality rates of each of these ethnic groups. (See graph "Low Birth Weight" and "Infant Mortality Rates" below)


Low Birth Weight
United States, 1988
Ethnicity of Mother
Mexican American
Puerto Rican
Cuban
South American
Chinese
Japanese
Filipino
Native American
Black
White
0%
2%
4%
6%
8%
10%
12%
14%
16%
Percent of Live Births
less than 2500 grams
Source: National Center
Health Statistics, National Vital
Statistics System

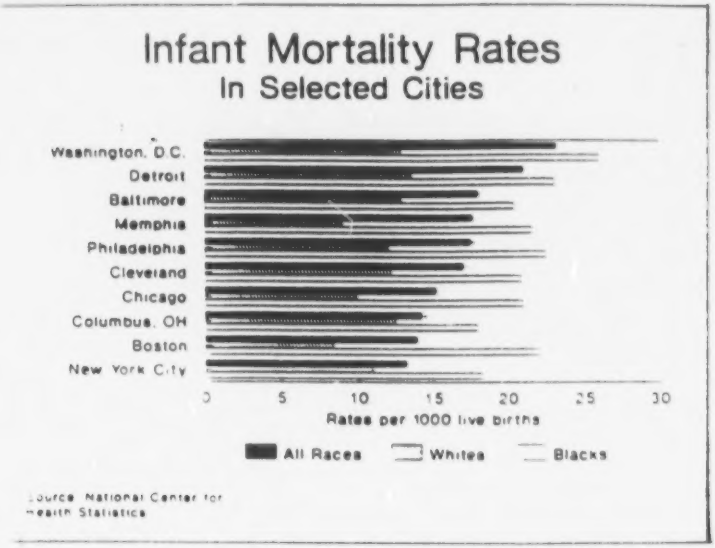

Infant Mortality Rates
United States, 1983-1985
Ethnicity of Mother
Mexican American
Puerto Rican
12.3
Cuban
Japanese
Indian
13.9
Black
18.7
White
0
5
10
15
20
25
Deaths per 1,000 live births
Source: National Center
Health Statistics, National Vital
Statistics System

- The link between early prenatal care and infant mortality rates only tells part of the story of infant mortality rates. For example, despite comparable or higher levels of early prenatal care, Blacks (61 percent of whom had early prenatal care) had infant mortality rates of 18.7 per 1,000 live births compared to Mexican Americans (58 percent of whom had early prenatal care) who had 8.8 deaths per 1,000 live births. **The Mexican American infant mortality rate was even lower than the rate for Whites (9.0 deaths per 1,000 live births), despite the fact that Whites had a much higher incidence of prenatal care of 79 percent.** (See "Infant Mortality Rates" graph above, and "Early Prenatal Care" graph below)



- **In D.C., the infant mortality rate is three times the national average** even though there is: free prenatal care to any woman whose family income is less than $20,000, eleven of the city's 16 health clinics provide prenatal care, there are maternity outreach programs that provide transportation to pregnant women and there are many private practitioners who cater to the Medicaid clientele. However, the all to frequent use of drugs or alcohol by women while pregnant undermines many of the services available. ("Stork Reality: Why America's Infants are Dying," Harmeet Singh, Policy Review, p. 62).

- The cities with high infant mortality rates are also cities with very high maternal use of drugs during pregnancy. For example, it is estimated that 25% of babies born in D.C. are born to addictive mothers. (T. Berry Brazelton, Progressive Policy Institute seminar, 4/12/91, Washington, D.C.) (See "Infant Mortality Rates in selected cities" graph below)



II. BEHAVIORAL ASPECTS OF HIGH INFANT MORTALITY RATES

- "Studies of whites, blacks and Puerto Ricans all suggest that low-birth-weight births and very-low birth-weight births in the U.S. **correlate strongly with behavior, not nutrition, and especially with smoking, drug abuse (particularly the abuse of crack and other forms of cocaine), previous abortions, stress and infections of the genital tract and of the membranes surrounding the unborn baby, which often result from sexual promiscuity.**" (Dr. George Graham of John Hopkins University, Professor of Nutrition and Pediatrics, The Wall Street Journal, April 2, 1991).

- Over 5 million women of childbearing age (15-44 currently use an illicit drug, including almost 1 million who use cocaine and 3.8 million who use marijuana. (National Institute of Drug Abuse [NIDA], 1989).

- The National Commission to Prevent Infant Mortality has estimated that **smoking is responsible for about 25 percent of all low birthweight babies and about 4,000 infant deaths each year.** (Select Committee on Children, Youth, and Families, "Beyond the Stereotypes: Women, Addiction, and Perinatal Substance Abuse," Testimony of Reed Tuckson).

- "Women who use cocaine are likely to use other substances such as cigarettes, alcohol, and marijuana. They typically have other poor health habits such as poor nutrition and lack of prenatal care, all of which affect fetal outcome. Therefore, cocaine is only one of many factors in a woman's lifestyle that contributes to a low birthweight and small head circumference among infants prenatally exposed to cocaine." (Pediatric Nursing, March-April, Vol. 17, No. 2, p. 125)

- **Both black and white unmarried women had a substantially higher risk of having infants with very low or moderately low birth weights.** (Kleinman and Kessel, Racial Differences in Low Birth Weight, The New England Journal of Medicine, Vol. 317, No. 12, Sept. 17, 1987, p. 749)

- **"Unmarried mothers are more than three times as likely as married mothers to obtain late or no prenatal care.** Unmarried white mothers are almost four times as likely as married white mothers to obtain late or no care; and unmarried black mothers are twice as likely as married black mothers to obtain late or no care." (Prenatal Care: Reaching Mothers, Reaching Infants. Institute of Medicine, 1988, pp. 38-39.)

- In Japan, even though a woman is four times more likely to die during childbirth than a woman giving birth in the U.S. because of our complex medical treatment service, Japan still has the world's lowest rate of infant mortality - about half that of the United States. In Japan, less than 1 percent of all mothers are either unmarried or teenagers. ("Stork Reality: Why America's Infants are Dying," Harmeet Singh, Policy Review, p. 63).

- **"Morbidity from infection is higher in the United States among those who are not breastfed, especially among the poor and the underserved...**Seventy-five percent of well-educated, middle to high income women breastfeed their infants. Less than 25% of low income women breastfeed their infants. Less than 25% of mothers in the WIC Program breastfeed their infants."

(Testimony of Dr. Ruth Lawrence before the Senate Subcommittee on Antitrust and Committee on Agriculture, March 14, 1991).

III. THE NEED FOR INTEGRATED SERVICES THAT REMOVE UNNECESSARY LAYERS OF BUREAUCRACY AND FOCUS ON BEHAVIORAL CONTRIBUTIONS TO INFANT MORTALITY AND CHILD HEALTH

- There are almost 100 federal programs administered by 20 federal agencies to address issues related to infant mortality. To state health care professionals, the burgeoning welter of agencies and programs related to infant mortality and prenatal care are more of a hindrance to their efforts than a help. ("Stork Reality: Why America's Infants are Dying," Harmeet Singh, Policy Review, Spring 1990, p. 58)

- In 1990 the Department of Health and Human Services spent about $4.3 billion on health care financing, services, and research related to infant mortality problems. The U.S. Department of Agriculture (USDA) spent roughly $2.0 billion for special nutrition programs. States spent an estimated $2.3 billion for their share of state Medicaid programs and public health departments of all types provided prenatal care, well baby and immunization services. (White House Fact Sheet: The President' Initiative to Improve Infant Health, Febuary, 1991)

- "There is now ample evidence that patterns of miscommunication, poor coordination, and emphasis on function rather than on mission plague our maternal health care delivery system. Congress has chosen to take a piecemeal approach to the problem of infant mortality...But Congress failed to make any fundamental changes in the administration of these programs. Congress has failed to look at the effectiveness of programs both individually and as part of a comprehensive system...Instead of making choices, we just add another program...It is time to reconsider the service delivery system itself." (Rep. Thomas Bliley, "Reducing Infant Mortality: An Organizational Strategy, May 21, 1990)

- "The money to pay for prenatal care is already out there"...."what is often lacking is the commitment of people who deliver the services...the most effective way to deal with the problem of prenatal care is to take most of the money out of the purely

public system and re-route it to other sources, be they private physicians or clinics like this. I think a little competition for the government is a healthy thing." (Maria Gomez of Mary's Center, "Stork Reality: Why America's Infants are Dying," Harmeet Singh, Policy Review, Spring 1990, p. 60.

- "Clearly our response to infant mortality must address the social value system which leads to negative personal behaviors and irresponsible actions by expectant mothers and fathers...We will increase treatment programs dealing with the major behavior-related causes of infant mortality -- smoking, alcohol, drugs, poor nutrition and high-risk sexual behavior." (Secretary of Health and Human Services Dr. Louis Sullivan, Remarks to the National PTA Legislative Conference, March 11, 1991).

ON THE FRONT LINES:
POLICE STRESS AND FAMILY WELL-BEING

MINORITY FACT SHEET

May 20, 1991

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I. POLICE WORK: A DIFFICULT JOB AT BEST

- Many sources of police stress such as the constant threat to an officers' health and safety, responsibility for protecting the lives of others, continual exposure to distressful situations, the need to be in control in explosive situations, and monthly shift rotations, are inherent in the nature of police work itself. (National Institute of Justice, "Coping with Police Stress," 1985, p. 4-5)

II. WHERE POLICE JOB STRESSORS ORIGINATE

- Monthly shift rotations from day to "swing" or "graveyard" shifts not only requires biological adjustment, but also complicates an officer's personal life. (Coping with Police Stress, National Institute of Justice, 1985, p. 4)

- Lack of consideration by the courts in scheduling police officers for court appearances often interfere with officers' work assignments, their personal time and even sleeping schedules. (Coping with Police Stress, National Institute of Justice, 1985, p. 5)

- Officers sometimes see themselves as having fewer rights than the criminals they apprehend. The rigid requirements of the legal system force the police officer into a narrow path of procedures which must be performed flawlessly. Police families know that the accused is not really on trial, but rather the job performance of the police officer. (Kennedy, "Police Marriages: Hazardous Duty?" Law and Order, 6/86, p. 55)

- Between 1985 and 1989:

    - Murder arrest rate rose by 16%
    - Forcible rape rate rose by 7%

- robbery offenses rose by 16%
- Aggravated assault offenses rose by 32%

(Uniform Crime Reports, "Crime in the United States", U.S. Department of Justice, 8/5/90.)

- While the number of crimes has increased, a Justice Department study showed that big-city police departments employed about 2.3 officers per 1,000 residents in 1987, compared with 2.4 a decade earlier. (U.S. News & World Report, "Cops under Fire," 12/3/90)

- There are more violent criminals, armed with more potent weaponry, showing more contempt for police. "Increasingly, police feel trapped between rising crime rates and an angry citizenry demanding immediate solutions to intractable problems. The FBI says reported violent crime rose 5 percent in 1989, even as law-enforcement officers made 7 percent more arrests than in 1988." (U.S. News & World Report, "Cops Under Fire," 12/3/90, p. 34)

III. HOW SUCCESSFUL POLICE FAMILIES COPE

- Both husbands and wives in police families have very similar coping patterns. The coping patterns rated as most helpful were: Doing things together as a family unit, adapting, developing strong interpersonal relationships, and self-reliance. For police couples to stay together seems to call for a high level of trust and a large amount of adapting behavior. The police officers' coping style heavily emphasized family life. (Maynard, Journal of Police Science and Administration, Vol. 10, No. 3, 1982, "Stress in Police Families: Some Policy Implications," p. 310)

- The police family lifestyle is atypical; it is probable that there will be more adjustment necessary for family members and more areas of conflict to resolve. If, during the early years in the relationship, a process for dealing with conflict is not maturely developed, anxiety and discomfort mount. The parties of the relationship must work out developmental tasks which were not addressed at an earlier, more appropriate time." ("High-Risk Lifestyle: The Police Family," by Special Agent, Roger L.Depue, FBI Law Enforcement Bulletin, August 1981, p. 11)

- The need for balance among occupational, family and individual needs is of utmost importance for the police family. The potential dominance of the police role is a clear challenge to this delicate balance. FBI Agent, Robert DePue states, "The job does not take precedence over the family, the job takes its place in the total balanced developmental scheme." ("A Police Wife's Guide to Survival," Law and Order, July 1986, p. 23)

IV. HOW COMMUNITIES CAN SUPPORT OUR POLICE FAMILIES

- Peer support groups and family seminars such as "Family Life Seminars" in Rockford Illinois involve officers and their spouses in discussing the components of police work that typically cause stress and strain in family life. (William Wentink, Police Chaplain, Rockford, Illinois)

- Police Chaplains are a primary means of support for many police officers and their families. The International Conference of Police Chaplains has over one thousand members nationwide who service officers and their families and there are hundreds of other chaplains working with police families nationwide. (International Conference of Police Chaplains, Livingston, Texas)

- "The greatest lift the nation could give its police is the promise that when they do their jobs well, it will amount to something...Currently for every 100 felony arrests, 43 are typically dismissed or not prosecuted. Of the remaining 57, 54 are disposed of by a guilty plea. Only 3 go to trial, of those, 1 is acquitted and 2 are found guilty. And of the 56 convicted, 22 typically get probation, 21 are sentenced to a year or less of prison and only 13 are sentenced to prison for more than a year." (U.S. News & World Report, "Cops Under Fire," 12/3/90, p. 44)

BABIES AND BRIEFCASES:
CREATING A FAMILY-FRIENDLY WORKPLACE
FOR FATHERS

MINORITY FACT SHEET

June 11, 1991

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I. WORK FAMILY STRESS: AN EQUAL OPPORTUNITY PROBLEM

- A 1989 survey commissioned by the Massachusetts Mutual Insurance Company found that Americans believe "parents having less time to spend with their families" is the single most important reason for the family's decline in our society. (Family Time: What Americans Think, Family Research Council)

- Nearly 40 percent of men (37.2 percent) and 40.9 percent of women say their job interferes with family life. (Fortune magazine survey of over 400 working parents, February edition, 1987)

- Nearly forty percent of men and sixty percent of women in the last three months missed at least one day of work due to family obligations. (Fortune magazine survey of over 400 working parents, February edition, 1987)

II. WHAT FAMILIES WANT

- Nearly eight of ten American men and women would be willing to sacrifice "rapid career growth" to spend more time with their families. In fact, nearly 75 percent of the men surveyed opted for a slower career path where they could set their own full-time hours and spend more time with their families. (The Best Jobs in America for Parents, Susan Dynerman and Lynn Hayes, 1991)

- When families are given a choice between two career paths -- one with flexible full-time work hours and more family time but slower career advancement, the other with inflexible hours but rapid advancement--78% preferred the family oriented track. (1989 Sanford Teller Communications survey, "What America Believes: The Rest of the Story," report by the Republican Staff

of the Select Committee on Children, Youth, and Families)

- More than 20 percent of men and 26 percent of women have sought less demanding jobs to get more family time. (Fortune magazine survey of over 400 working parents, February edition, 1987)

- A recent study found, "25 percent of the men and 50 percent of the women said they had considered seeking another employer who offered more work and family flexibility." A 1989 study found "74 percent of men said they would rather have a 'daddy track' job than a fast track job." ("Split-Shift Parenting," February issue of American Demographics magazine)

- In surveys by Johnson & Johnson and Du Pont, employees cited flexibility as the top family-friendly policy preferred. This preference was over on-site child care or other child care assistance. (The Best Jobs in America for Parents, Susan Dynerman and Lynn Hayes, 1991)

III. THE QUIET REVOLUTION-- OFF THE FAST TRACT AND ONTO A "FAMILY TRACK"

- More than half (56 percent) of working mothers surveyed in a 1989 poll and 43 percent of the working fathers had cut back on their hours in order to be with their children. (1989 Washington Post/ ABC News Poll)

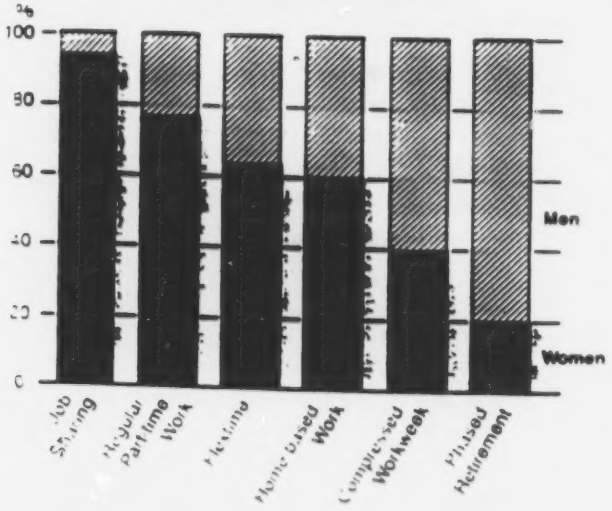
- Although 52.5 percent of mothers with children under three years old are working, one-third are working part-time, leaving only 35 percent of mothers working full time. (Bureau of Labor Statistics, Bureau of the Census, 1990)

- Robert Half International, recruiters in the field of finance, found that 75 percent of the men they recruited opted for a slower career path where they could set their own full time hours and spend more time with their families. "All of this suggests that the Mommy Tract should have been dubbed the Parent Tract." (The Best Jobs in America for Parents, Susan Dynerman and Lynn Hayes, 1991)

- Despite the fact that more and more companies are offering leaves to new fathers, very few men are taking them. It is fairly common for fathers to take a few days off at the time of the

child's birth, but they rarely request this time as a separate paternity leave. (National Study of Parental Leaves, Catalyst, in the Bureau of National Affairs "Work & Family" report, 1986)

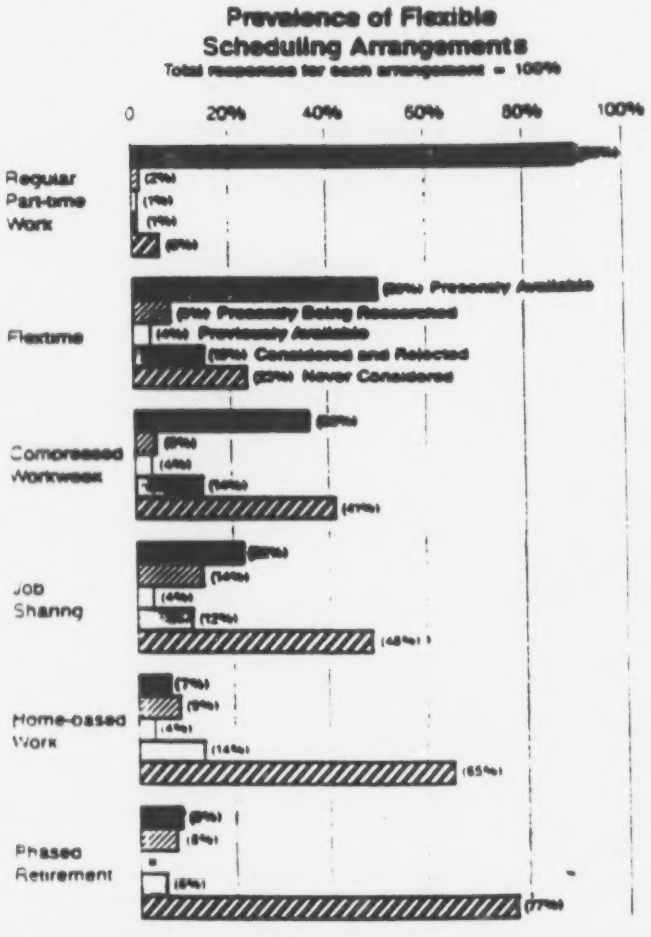
Distribution of Men and Women Using Flexible Schedules



Source: "Flexible Staffing and Scheduling in U.S. Corporations," by Kathleen Christensen, The Conference Board Inc., New York, New York, 1989)

Women outnumber men in utilizing alternative work schedules in four out of the six alternative work arrangements. The most female intensive arrangements are job sharing (almost 90% women) and part-time work (approx. 80%). Women represent 60% of home based work and these women are often in professional and managerial positions. Men predominate in only compressed work schedules and phased retirement. The Conference Board reports that "the high proportion of women using family-responsive work options may, in fact, also reflect women's stage of life at least as much as - if not more than - their gender." Flexible Staffing and scheduling in U.S. Corporations, by Kathleen Christensen, The Conference Board, 1989)

WHAT COMPANIES ARE DOING



Source: "Flexible Staffing and Scheduling in U.S. Corporations," by Kathleen Christensen, The Conference Board Inc., New York, New York, 1989)

In this 1989 Conference Board survey nine out of ten firms surveyed utilized at least one of the six flexible scheduling arrangements. Part-time work was one of the most widely available arrangements (offered by 90 percent of firms surveyed). Flexitime programs are the second most popular alternative scheduling option with half of the surveyed firms offering it, representing a three-fold increase since 1979. Job

sharing and home-based work are the two arrangements most likely to be under consideration by those surveyed and over half of the firms surveyed anticipate increasing their use of all types of flexible schedules.

Flextime

- An extensive study examining the effects of flextime on productivity revealed that flextime has either a positive or neutral effect on productivity but does not result in any decrease. In general, the consensus in these is that flextime increases employee morale at little to no cost to the firm. Of those firms offering flextime, 86 percent are satisfied. ("Flexible Staffing and Scheduling in U.S. Corporations," Kathleen Christensen, The Conference Board, 1989)

- Based on productivity measures developed in 12 studies examining flextime, productivity increased by a median level of 12 percent, with a range from zero to 45 percent. ("An Overview of Employee Benefits Supportive of Families," Nancy Saltford, EBRI, 1990)

Job Sharing

- Of the firms that offer job sharing, 91 percent are satisfied with performance levels. ("The Flexible Scheduling and Staffing at U.S. Corporations," Kathleen Christensen, The Conference Board, 1989)

Home-based Work

- Forty percent of the individuals who work from home for a company are men. Motivations behind telecommuting include spending time with family, cost savings, productivity, and avoiding traffic congestion. Nearly 80 percent of supervisors were satisfied or very satisfied with job performance. ("The Flexible Scheduling and Staffing at U.S. Corporations," Kathleen Christensen, The Conference Board, 1989)

Part-time Work

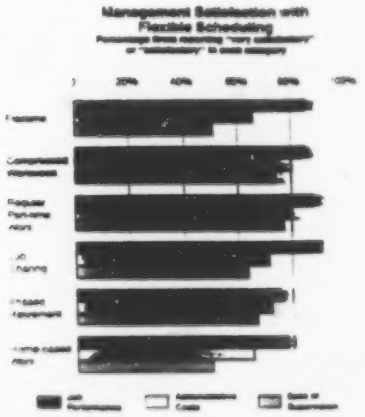
- Nearly 90 percent of supervisors who have regular part-time employees are satisfied or very satisfied with performance. Nine out of ten companies surveyed offer part-time work. ("Flexible Staffing and Scheduling in U.S. Corporations, Kathleen Christensen, the Conference Board, 1989)

IV. WHY FLEXIBILITY?

- Retention was reported as a motivation for implementing flexible work arrangements among 64 percent of human resources professionals and 68 percent said flexible work arrangements had affected retention positively. ("Flexible Work Arrangements: Establishing Options for Managers and Professionals," Catalyst, in a survey of 150 human resource professionals, 1990)

- Almost two-thirds (65 percent) of employers surveyed reported that employees who utilize flexible work arrangements sustained higher productivity. (Flexible Work Arrangements: Establishing Options for Managers and Professionals," Catalyst, in a survey of human resource professionals, 1990)

- Once firms do implement a flexible arrangements they are not likely to rescind it. Less than 4 percent of firms surveyed reported that any one arrangements that had been previously available was no longer in use. ("Flexible Staffing and Scheduling in U.S. Corporations," Kathleen Christensen, New York, New York, 1989)



Source: "Flexible Staffing and Scheduling in U.S. Corporations," by Kathleen Christensen, The Conference Board Inc., New York, New York, 1989)

- An overwhelming majority of firms were satisfied with the job performance of those utilizing flexible schedules, but the challenge to American businesses seems to be to learn how to manage employees under these schedules. The Conference Board reports that "assessments about difficulties in direct supervision may be reflections of inexperience at best and corporate resistance at worst." ("Flexible Staffing and Scheduling in U.S. Corporations," The Conference Board, New York, New York, 1989)

- Eighty-six percent of 7,500 companies surveyed recently had plans to develop some kind of work/family program. (The Families and Work Institute, The Best Jobs in America for Parents, Susan Dynerman and Lynn Hayes)

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